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GROUP PSYCHOTHERAPY

A SYMPOSIUM

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ACKNOWLEDGMENTS

FOREWORD

Two trends of thought, converging now and here, make most logical an intensified interest in the application of psychotherapeutic methods to and within the group—one is the recognition of the truth long emphasized by Meyer and White, that behavior is the result of the response of the organism-as-a-whole to environmental influences among which people are the most important; the other is the fact, demonstrated all too painfully during the recent war, that the supply of psychiatrists is far below the demand. Thus whether we view the needs of the situation theoretically, interpreting psychiatry as dealing primarily with interpersonal relations, or practically, recognizing the fact that we must either multiply the number of psychiatrists or divide their applicability by treating several patients simultaneously, we are inescapably forced to recognize the need and value of group psychotherapy.

In the development of this form of treatment one thinks especially of the pioneering work of J. L. Moreno, the exponent of sociometry and of psychodrama, whose originality, continuing guidance and enthusiastic support have been an outstanding influence through the years. It is no detraction to this pioneer to mention another—an internist of keen psychiatric insight, Dr. Joseph H. Pratt, of Boston—who is perhaps, next to Moreno, the most important of the early workers in group psychotherapy.

It was not, however, until the Round Table Conference at the Philadelphia meeting of the American Psychiatric Association in 1932, presided over by the late Dr. William Alanson White, that a large and representative group of psychiatrists met for a discussion on the topic; indeed, the phrase, "group psychotherapy," had first been given currency (by Moreno) only a year before! It was characteristic of Dr. White's progressive spirit that he should have discerned the psychiatric possibilities of this approach and given it support. It was completely in line with Dr. White's tradition that one of his associates, Dr. Roscoe W. Hall of St. Elizabeths Hospital, should have acted as chairman of the conference on Group Psychotherapy at Philadelphia in 1944, and that in the interval St. Elizabeths Hospital should have become the first public mental hospital in the United States to introduce Moreno's psychodrama. It is therefore with peculiar pleasure that as a representative of that Hospital I have accepted the invitation to write this foreword.

This volume presents among other papers the account of the 1932

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and 1944 conferences, and thus gives the past and present. The possibilities of psychodrama as a teaching method are just being tapped, and the treatment potentialities of group psychotherapy are far from fully explored. There is thus a future, yet to be presented; perhaps the next volume may illuminate further the path that now lies ahead.

Washington, D. C.
October 17, 1945

WINFRED OVERHOLSER, M.D.
Superintendent, St. Elizabeths Hospital.

THE APPLICATION OF THE GROUP METHOD TO THE CLASSIFICATION OF PRISONERS

A Round Table Conference at the Annual Meeting,
American Psychiatric Association

Philadelphia, Pa., May 31, 1932.

Chairman

DR. WILLIAM A. WHITE

Those present were:

Dr. Franz Alexander, Cambridge, Mass.

Dr. Albert Anderson, Superintendent, State Hospital, Dix Hill, Raleigh, N. C.

Dr. Amos T. Baker, Director of Classification, Sing Sing Prison, Ossining, New York.

Dr. Harry B. Ballou, Assistant Superintendent, State Training School and Hospital, Mansfield Depot, Conn.

Dr. P. B. Battey, Superintendent, Westfield State Farms, Bedford Hills, New York.

Dr. C. R. F. Beall, U. S. Penitentiary, Atlanta, Ga.

Dr. A. L. Beier, Chippewa Falls, Wisc.

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Dr. Malcolm A. Bliss, St. Louis, Mo.

Dr. V. C. Branham, Deputy Commissioner of Correction, Albany, N. Y.

Dr. Rene Breguet, Elmira, N. Y.

Dr. Charles M. Burdick, Medical Superintendent, Dannemora State Hospital, Dannemora, N. Y.

Dr. Noble R. Chambers, Syracuse, N. Y.

Dr. Charles E. Clark, Trenton, N. J.

Dr. Edwin W. Cooke, Superintendent, Western State Hospital, Bolivar, Tenn.

Dr. Lawrence M. Collins, Senior Assistant Physician, New Jersey State Hospital, Greystone Park, Morris Plains, N. J.

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Mrs. Kate Burr Johnson, Superintendent, State Home for Girls, Trenton, N. J.

Dr. E. R. Johnstone, Director, Training School, Vineland, N. J.

Dr. Benjamin Karpman, St. Elizabeths Hospital, Washington, D. C.

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Dr. Amy N. Stannard, Washington, D. C.

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Dr. Coronal Thomas, St. Louis, Mo.

Dr. Kenneth J. Tillotson, Medical Superintendent, McLean Hospital, Waverley, Mass.

Dr. Frederick I. Wertham, Associate in Psychiatry, Johns Hopkins Hospital, Baltimore, Md.

Mrs. Frederick Wertham.

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Mrs. William A. White.

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PROPOSAL OF A PLAN OF GROUP PSYCHOTHERAPY

READ BY DR. WILLIAM A. WHITE

"The proposal for the Application of the Group Method to the Classification of Prisoners has grown out of a luncheon conference arranged by the National Committee on Prisons and Prison Labor through the courtesy of the American Psychiatric Association at our meeting in Toronto, last year, 1931, at which many of you were present. Dr. J. L. Moreno suggested group psychotherapy of prisoners and as a result the authorities of the New York State Department of Correction permitted Dr. Moreno in collaboration with Dr. E. Stagg Whitin, Chairman of the Executive Council of the National Committee on Prisons and Prison Labor, to carry on research at Sing Sing Prison. Through their efforts, the plan has developed which is the topic of our round table discussion."

DR. WILLIAM A. WHITE,
Superintendent, St. Elizabeths Hospital,
Washington, D. C., presided:

After reading the Proposal stated:

The whole penological system is probably the last ditch "for man's inhumanity to man" to yield. It is natural and hopeful that psychiatry is directing its interests into the wide field of penal reform. There have been a number of approaches, first that of the hospital and then the individual analysis. Tonight it is the group psychiatric approach which we will consider.

I remember visiting, a few years ago, a prison in the East with about one thousand inmates. It had no walls and only a few cells. The dormitory system, similar to that in schools, was in use. On the first occasion I found no men in the solitary cells and on the second occasion only one. The men were free to conduct themselves and the warden was clever enough to handle the men so that they felt comfortable. They did not run away nor did they commit acts which would have made the running of the prison impossible. The warden in his dealings with these men relied largely upon his "intuition." This is a vague term, I know, and one much over-used, but I cannot find any other word to express the way in which he managed his men.

I speak sometimes of the inter-weaving of emotional streams among people when they are in a group. These emotional streams bind people who thus can be modified to and by the group. Ten or fifteen men within a prison can and do sometimes bind themselves together and so gain control of the prison. The others have to do as they demand or their life is threatened. This domineering group which takes the command of the prison even out of the hands of the personnel may be segregated: that is one method. The other, the one which concerns us today, is to study the emotional cross patterns, to study whether groups within the prison cannot be formed advantageously so that the men will live better and to the advantage of their fellows. This is the relating of the men to one another. Moreno calls this approach. "Group Psychotherapy." As I looked over the portion of Dr. Moreno's monograph which deals with the structure of social groups, I was interested in the charts illustrating them. They look like formulas in a book on chemistry. They reveal how strange and complicated are human inter-relations and also how much we can profit from the study of these structures in the successive stages of their development.

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Dr. Moreno, in a discussion with me just before this meeting, said that the family is a rigid form of social grouping. We are not able to take a parent or some of the children out and place them with some others, substitute other parents or children, and so forth. But if groups are formed in a correctional institution, we *are* able to shift the persons from one group to others for their advantage and for the advantage of the others. These groups need not be rigid. They can be made flexible. Into the forming of these groups all the factors uncovered about the individuals may be synthesized. The knowledge which we have gained will go into the very foundations of the groups.

On this unusual occasion of the large assembling here of outstanding psychiatrists, criminologists, and experts in particular branches of penology, it would be impossible for me to call upon all whom we should like to hear speak. I shall try, however, to make the discussion as widely representative as time will permit, leaving it to you, Dr. Moreno, as the last speaker, to clarify all questions which may arise.

First may I call upon you, Dr. Vernon C. Branham, who, as Deputy Commissioner of Correction for New York State, have always given freely of your interest and encouragement to every new and promising experiment within the correctional field and in particular during the past year have done all in your power to make possible the present research.

DR. V. C. BRANHAM:

In the consideration of this plan we are confronted from the very first with the general prevalence of the old concept of an eye for an eye and a tooth for a tooth in dealing with the criminal. Guilt was determined through trials by ordeal and a regime of torture.

In recent years only, has an approach been made to the prisoner himself. Lombroso emphasized the anatomical structure of the criminal. The next stage was biological and psychological. The psychiatric approach came later and showed that feeble-mindedness and insanity may make for irresponsibility and criminal acts, and that distorted attitudes from early childhood may be influential. At last came the sociological aspect which emphasized that crime flourishes in certain districts under certain environments.

The plan elaborated by Dr. Moreno, it seems to me, is the climax of these different efforts as it combines the individual with the biological, the psychiatric with the sociological, urged by the aim to transform the prison

into a cohesive, integrated, socialized community. Until the present time, the two ends, the abstracted individual and the undisciplined mass, have been studied, the one and the many. But the social structures formed by men between these two extremes has scarcely been touched. Yet man lives neither as an individual for himself nor in a mass, but in small coteries in which he attracts or repels and it is through his relation to these men that his personality is developed. This is the starting point of Dr. Moreno's plan. The question put forward is: Is it possible to form coteries of this sort synthetically? To answer this question he analyzes the inter-relations of men to one another and places them into groups as appears to their best advantage. Out of this attempt an analysis of inter-relations and a system of scoring grew which even in its beginnings contains a promising direction for research and the germ of a workable method for social organization.

This conference, I believe, should not attempt the discussion of these very important technical studies, which may be left for a later time, but should concentrate upon the larger aspect, the group treatment in correctional institutions. A new principle of approach confronts us and I am convinced that it will lead to a change in our outlook and our procedure.

DR. WHITE:

Throughout all society's dealings with the criminal, both in court and elsewhere, the act has always been considered rather than the actor. At best this is a very imperfect method. And even when the psychiatrist comes to understand why the criminal did commit the particular act, this is also insufficient. He again must consider the doer of this act and his inter-relations with other people.

It will be interesting to hear now the opinion of one who deals continually with the classification of prisoners and who is able to tell us if and how the group method can be applied to a large prison population. I hope Dr. Amos T. Baker who is the director of the Classification Clinic of Sing Sing Prison will do that for us.

DR. AMOS T. BAKER:

My expectation was that Dr. Moreno would present a paper on the group method first and I should then have, after him, an opportunity to contribute my ideas. Thus I was prepared to ask certain questions. I feel I am in the position of a patient whom I treated at Matteawan some years ago.

He had received no answer which he considered satisfactory relative to his situation, and so he spent a long time in making a great list of questions which he intended to ask the physician. Confronted with the decision that he would not be allowed to ask all of them, he said: "Well, then, I will display them in evidence." Now I have asked a lot of questions about Dr. Moreno's plan but have not yet been able to have them all answered. So tonight I intend to take this opportunity to display them in evidence.

Much time has been given to classification but no plan has evolved which has met the approval of the prisons. Certain prisoners have been segregated, such as the psychotic and the feeble-minded, the tubercular, etc. Two plans are actually in use in New York State: The diagnostic plan which was adopted about 1926 by the legislature and an administrative plan, devised by Dr. Branham.

I believe that the groupings of inmates is possible. But I would warn against too hasty application to a prison and would suggest first a try-out in small institutions. There are a number of practical rules which will be gained through experience. The second step would be a try-out in a new prison which is from its beginning better adapted to the demands of the group method. In respect to the classification of the men into groups, I would place greater emphasis upon the prognosis of each of the men. Symptomatology, diagnosis and prognosis are the three principles upon which group classification should be based.

Does Dr. Moreno consider the following difficulties: Will the leaders be recognized as "leaders"? What are the objectives of classification? Should not the younger group be kept apart in a special prison? Of every one hundred arrested for a felony, only eight are convicted. What about the ninety-two, guilty or not guilty, who remain in the community?

DR. WHITE:

It happens quite often that men who work in a certain direction for a long while lose the freshness of thought and the daring to try out something new. What we are interested in is taking the new in Dr. Moreno's ideas and finding out what it is worth. We are not interested in where it comes from but in getting something to use. Then we will find out what can be done.

Some years ago Congress made an appropriation for a prison for Washington, D. C. Roosevelt picked a committee to decide upon recommendations and plans. Among those he chose was a banker, a very well-known

philanthropist. Hearing of his appointment, the man immediately protested, saying: "I cannot serve upon this committee. I know nothing about the project. I never was in a prison in my life." The President responded: "That's just why I want you." A prison was erected without walls and with no cells. It still functions successfully. It is true the warden had selective authority as to who went to his prison. But he had no scientific means of knowing whom to allow and whom not. Probably he did it largely by intuition.

This at least suggests the question whether our methods of managing our prisons, are antiquated. Maybe a naïve unsophisticated approach will bring us closer to the heart of the matter. We have seen this happen so often in the history of science and social reform. Now perhaps someone who is in charge of guiding the development of children (whom we call delinquent because we have no better word) will be able to supply us with this wider attitude towards the question. I will ask Mrs. Fannie French Morse to speak, who is the Superintendent of the New York State Training School for Girls, where Moreno's plan is being put into concrete application.

MRS. FANNIE FRENCH MORSE:

For the past thirty years I have been dealing with children in and out of institutions, and out of this contact has been born in me a persistent conviction that personality is the greatest single force to be considered in handling them. Even in institutions the greatest factor is personality. But how is it possible to put this influence of personality methodically to work? I have tried to do this largely by intuition, but I believe that Dr. Moreno's method makes the procedure accurate and controllable. Therefore when he addressed my staff, we all realized that what he placed before us in distinct logical terms was the thing we had always felt the need of without being able to express it.

For years I have protested against the mechanical measuring of the child. For a long time I arranged the cottages according to psychological measurements. But I have never gone back to it. Something higher is needed. The social fitness is the real criterion. More and more I am releasing the child, her spontaneous life. And I must say, it seems to work. Why does one child choose another? It is not because they are the same in intelligence or in some other factor, but because there is something in one which appeals to the other. This "socializing" process is the great point in developing human beings.

DR. WHITE:

This is a hopeful note, and what is true for the adolescent cannot be entirely untrue for the adult delinquent. I wonder if another woman of distinction in the correctional field, Miss Julia K. Jaffray, Secretary of the National Committee on Prisons and Prison Labor, and also a member of the Board of Advisors, Federal Industrial Institution for Women, will tell us the reaction of the people-at-large in our community towards this matter.

MISS JULIA K. JAFFRAY:

I bring greetings to this gathering from Mr. George Gordon Battle, the President and the Board of Directors of the National Committee on Prisons and Prison Labor, and also two messages:

First, the prisons are rapidly reaching the place where they can carry on constructive work. The old slave system under which the prisons suffered for almost one hundred years has been broken down through the passage of the Federal Law, known as the Hawes-Cooper Convict Labor Act. This act becomes effective in January, 1934, and will bring about the abolition of the prison contract system under which the labor of the prisoners has been sold to private business interests. Graft and brutality are passing out of the prisons and gradually men of high calibre with a broad educational viewpoint are being recruited for the prison service. The time is ripe for constructive work in the prisons.

My second message is that it is to men like yours that we must look for leadership and guidance in the development of the new prison methods. We ask you from the National Committee on Prisons and Prison Labor to give to the prisons your very best and we have every reason to feel confident that the method of grouping will be accepted and applied in the spirit in which it is given.

DR. WHITE:

Moreno's method of grouping lays due emphasis upon one factor, the personality of each individual man. To develop the group method successfully we must not only know the inter-reaction of individuals with others but must also know each individual. Psychoanalysis has revealed to us many important facts in regard to the individual. What has it to contribute in respect to method of grouping? Dr. Franz Alexander, Professor of Psychoanalysis, University of Chicago, outstanding in the field of psychoanalysis and who has spent much time in the study of criminals, may

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be able to tell us what he considers the deeper determinants of criminality, and in what respect he considers the group method applicable to the study of crime.

DR. FRANZ ALEXANDER:

My knowledge of criminals has been very limited. I know very few because I have been burdened with their psychoanalysis. But I may say that I know those few very well. With Dr. William Healy working for the Baker Foundation, we have handled eight cases which would fill three volumes. Our results have led us to make a distinction between the psychological criminal and the sociological criminal. And the more I deal with criminals the more I am convinced that the therapeutic treatment of them cannot be solved by the sociological or the psychological alone.

This is demonstrated by the fact that certain areas of the world's large cities contain twenty times the number of criminals produced by other areas. Only a certain percentage of the persons living in the criminal areas becomes criminal, and that means there is a certain class more susceptible to criminal impulses than others.

Tendencies cannot be traced to economic reasons entirely, either, because the majority of us faced with starvation would perish rather than commit crime.

Those who break the laws are, however, found to be those who come from the strata which is least interested in upholding the law. But still only a certain percentage even here become criminals. It works on a basis of selection. Which are those? It is a problem for psychiatry. Before we go on readjusting criminals we have to classify the etiological factors and the social factors which led to the committing of crime. Those earlier family influences, etc., were the same for many. But only a few became criminals. What is the explanation? It is of first importance that the psychiatrist should divide criminals into two classes, those who are forced by the economic instinct of self-preservation and those who enter lives of crime because of prenatal or early family influences which cause psychological maladjustment.

Aggression against the family leads into aggression against society. The child victim of a brutal father or bullying brothers sometimes turns aggressor against them and this results in the aggression against society as a whole when the individual reaches criminal age.

Many criminals have confessed that after the commission of a crime

they felt a relief from anxiety and fear disclosing that in some cases criminality gives opportunity for getting rid of the effects of emotional maladjustment.

Another who cannot outgrow his criminal tendencies may have a neurosis. Emotional tension is sometimes relieved by holding up a store. Criminality in this way displaces a neurosis. I do not know if Dr. Moreno's group plan can help in the psychological cases which are due to early experience. But it may be very helpful for the sociological cases. With the psychological cases, changes in the environment did not aid, we found. Criminal behavior is the same as a maladjustment of neurosis. Readjustment which is a psychological problem can only take place with psychological individual treatment. And the jail is not the place in which to make a psychological approach. Those who need it must be "sentenced" to hospital care not to prison.

DR. WHITE:

I wonder if it is possible to make a distinction between the social and the psychological criminal as Dr. Alexander says. It seems to me that this distinction is rather one of degree. These two factors are always so interwoven that we have to recognize the fact that there are quantitative but no qualitative differences between them. If this is true, then the contention that there is need for a different approach to these two types of cases can be doubted. The criminal got his values as a child from his environment and the psyche itself is part of that environment. The two are so interjected into each other that it is not possible to make a clear distinction.

Even if it should be maintained that the individual approach is the best, it still remains a hopeless problem to psychoanalyze everybody. Torture also as a means of punishment we know activates aggressiveness in all prisoners. Can we not rely upon the bonds among men as a means of reforming them?

We have heard from the psychiatrist, the educator, and the psychoanalyst. Now we would welcome the opportunity to hear what the administrator and expert in prison organization will add to our discussion about the group plan. I should like to introduce the Commissioner of Institutions and Agencies of the State of New Jersey, Dr. William J. Ellis.

COMMISSIONER WILLIAM J. ELLIS:

There is a distinction, that from the *same* environment some commit crime and others do not. But I would suggest that there is a third group: Those who commit crime and get away with it.

The difficulty as I see it of applying Dr. Moreno's plan to the prison of today lies in two big facts: One is the architecture and the total make-up of our prisons; the other is the personnel. The cramped quarters and the limited qualification of our personal are the mechanical hindrances for a try-out.

I would suggest the application of the group method to the juvenile training schools and if the results there suggest it, to build more suitable prisons and to educate better fitted personnel to carry out the plan to its fullest possible success. I see a slow and gradual development instead of a quick and hasty change of procedure.

I am sure that the other representatives from New Jersey who have studied the plan will be able to throw light upon other phases of the group method.

DR. WHITE:

It is time, I think, that we direct our attention for awhile to the technical aspects of the Group Method as such. I am going to ask someone who has taken the time to study the method in its particulars, Dr. F. Lovell Bixby, Director of the Division of Classification and Education in the Department of Institutions and Agencies of New Jersey, to treat this subject.

DR. F. LOVELL BIXBY:

I have had the opportunity to discuss personally with Dr. Moreno his principles and methods of grouping after reading again and again his written material. I believe that it is an important contribution, very stimulating to thought indeed. Therefore, I am sorry that so much time has been lost by general discussion instead of arguing about the method of grouping itself.

One of the principal thoughts in Dr. Moreno's plan is to recognize that *persons affect one another in a direction advantageous or disadvantageous for them* and that we should not stop in recognizing this fact but attempt to make use of this principle through a well calculated *strategy of procedure.* It cannot be doubted that this thought is fundamental. I remember how well my own boy gets along with his friend next door. But when sometimes his cousin comes, there are quarreling, arguments, and discordance generally. Obviously the intrusion of the third boy into the picture has changed the relationship between my boy and his friend.

Dr. Moreno attempts to study systematically these interactions and

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their products, aiming to find criteria and to suggest the placing of a man in the same group with certain other men or warn against it. Here is the place where I cannot entirely follow Dr. Moreno. I do not believe that psychology or psychiatry is at a point where it can be foretold what the relationships so arranged will produce. We cannot even foretell what the relationships of two individuals will result in. How could we foretell what the outcome of the relations between eight or ten persons would be whom we have placed together into the same group? However, Dr. Moreno's proposition may be a beginning and as the principle is sound, I can see that progress in this direction can be made.

Still less satisfactory seems to me the division into the conserving and spontaneous reaction types. We cannot divide the prisoners any more this way than we can into the introvert and the extrovert. They are in themselves a group product anyway. I know I am more spontaneous with some people than with others. As to the scoring system, Dr. Moreno has constructed to estimate the degree of value one man may have for another, our emphasis should lie rather than on mere summation of the beneficial or disparaging factors, on their integration.

DR. WHITE:

Let us hear more about group technique. I will ask the Director of the Department of Research at the Training School at Vineland, New Jersey, Dr. Edgar A. Doll.

DR. EDGAR A. DOLL:

This afternoon I also had the opportunity to find out more about Dr. Moreno's idea by having a talk with him.

It seems to me that the group method is extremely important but not yet comprehensive enough. I can see its mental hygiene value as long as the man is in prison. But the improved status of the man within the prison would not determine the correctional value of the plan. The man has failed on the outside. If we make it easier for him on the inside and less complex do we not send him back into the community untrained and unprepared for the more complex situations?

The technique of group classification ought to lay more emphasis, as Dr. Baker said, on the symptomatology and prognosis of each man. We ought to develop treatment according to causation, physical, mental, personality, etc.

In prisons as they are today it is hardly possible to use this method. Possibly institutions for the juvenile will find it valuable.

DR. WHITE:

Let us hear now from Dr. Quinter Holsopple of the Department of Institutions and Agencies in New Jersey.

DR. QUINTER HOLSOPPLE:

Listening to the various speakers tonight I am reminded of the way one feels sometimes during the giving of the Form Board Test, when the subject gets stuck and persistently attempts over and over again to put the wrong piece into the space. You cannot stand it any longer and you want to say: "Oh take them all out and start over again." But since we are giving the test, we can not say that, we have to go right on watching. Now it seems to me that we have about come to the point I speak of here tonight.

Let us go back to the start, to the fundamental issue, to what Dr. Moreno is driving at. He has pointed out that the *psychological products which emerge from the group are of profound importancee.* Since they come from the group Dr. Alexander's distinction between the sociological and psychological criminals is untenable. Certainly every act has psychological and sociological determinants. We ought to study the complete products of inter-relations and base upon them a better balanced system of social organization than we have today. I agree with Dr. Moreno that it is in this direction that we must work if we want to develop the correctional institution beyond its present state.

Also the value of the *Spontaneity Test* cannot be determined through a discussion but through an actual try-out. I intend myself to make use of it as one in the battery of tests we are trying out at present and am looking forward to interesting results.

DR. WHITE:

I should like to ask for several more opinions before I come to Dr. Moreno.

Let us hear now from a representative from Illinois, Dr. Paul L. Schroeder of the Institute for Juvenile Research.

DR. PAUL L. SCHROEDER:

I was impressed with the plan as a technique. To put it into successful practice a different type of personnel has to be trained, however. At

present the officers are too much concerned with the offenses the inmates have committed and too little with the men themselves. The success would largely depend upon the personnel employed.

—Contrary to common belief, delinquents and criminals tend to develop group feeling of a cohesive nature. In view of this approach their rehabilitation can be effectively brought about through the group approach. The matter of cohesion is not clearly understood, however, it appears that it stems from a feeling of similarity in their relationship with society in general and persons in authority individually. Use can be made of this common feeling not only during the period of institutionalization but possibly also in the early period of their return to their local community.

It was with this in mind that the Institute of Juvenile Research organized and established a local neighborhood program for the study and treatment of juvenile delinquents under the title of the Chicago Area Project. This program has been in effect since 1931 and has been extended to a number of delinquent communities in Chicago. The progress made fully justifies the philosophy that the control of delinquency and crime in the local community must come through an awareness of the people of that community of its need and be effected through their own efforts.—*

DR. WHITE:

Let us hear from another woman who has distinguished herself through her work as Commissioner of Welfare in Pennsylvania and who is now Director of Medicine for the Department of Institutions and Agencies in New Jersey, Dr. Ellen C. Potter.

DR. ELLEN C. POTTER:

Personality as a factor in treatment is certainly extremely important. It seems to me also that the question is: how would it be possible to secure personnel to put this plan into operation? I do not believe we are staffed now to do it properly.

DR. WHITE:

We should like to hear from the State of Massachusetts: Dr. S. W. Hartwell, formerly with the Judge Baker Foundation.

DR. S. W. HARTWELL:

If any of us change, it is because of other people. We change through the personality equation. It seems to me that *this plan is the only plan that*

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*The text between dashes (— —) has been added by Dr. Schroeder, October 1945.

can ever help to change the criminal. It can make him more stable in his emotional life and mentally more healthy. And we cannot do this without relating him to other persons.

DR. WHITE:

Perhaps Dr. Benjamin Karpman who works with the criminally insane at St. Elizabeth's Hospital in Washington, D. C., will say a few words.

DR. BENJAMIN KARPMAN:

How can a physician have come to the group notion? I do not understand. The group method arises as a compromise as we cannot afford the other, the individual method. The only way to secure results is by a complete individual study and if we have that then we will not need the group method. Also it is known that prisoners get along very well with other prisoners anyway.

—It seems to me that group psychotherapy can only be done in cases where there is a certain community of emotional interests among those who compose the group, as well as in their attitude toward the therapist or the leader of the group. No such thing is possible so far as I know in work with criminals. For one thing the criminal looks on everybody outside of the prison inmates as people entirely foreign, even inimical to his interests. As the saying among them is: "We are on the inside looking out; you are on the outside looking in, and we can never understand each other." Though among themselves criminals are reputed to be very loquacious and friendly, this is not really the case. There is a great deal of bragging among them, as one telling the other what wonderful crimes he has committed, how he cheated the law more than the others, and what a master-mind he is. Of his real problems he rarely talks either to prisoners or outsiders, and would not talk as long as there is the wall between him and the outside world. Therefore, I cannot see in the present state of affairs how group therapy with criminals could be at all possible. Even individual therapy is fraught with many difficulties, but with all the difficulties, it is the only one which is at present available. The difficulties consist in the chinese wall of hostility that exists between prisoners and the outside world. For hours and days and weeks the man would just bluff and bluff. One has to know how to penetrate the thick fog which separates him from the rest of the world and then he may open up. Instead of expecting transference to develop in the usual way as we get among neurotics, it is our turn to give

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him transference. We have to give him undoubted evidences of genuine affection in order to desolve the tremendous amount of thick hostility that has accumulated in him.

No! So far as I can see and for some time to come yet, criminals will have to be treated on strictly individual basis and with greater sacrifice than is required of us with any other type of neurotic.—**

DR. WHITE:

Now that we have heard the most varied attitudes towards the topic of our discussion, I beg Dr. E. Stagg Whitin, Chairman of the Executive Council of the National Committee on Prisons and Prison Labor, to express his point of view as one who has worked in the prison field for over twenty years.

DR. E. STAGG WHITIN:

On behalf of the National Committee on Prisons and Prison Labor and in confirmation of the words of appreciation to the American Psychiatric Association already voiced by Miss Jaffray, my colleague, I desire to emphasize the importance of this gathering. While warring against administrative and economic abuses in our prisons, the committee has ever been mindful of the individual prisoner, and his rehabilitation. We have been trained by the medical and psychiatric leaders on our boards to look to these groups for the answer of the personal problem of the prisoner.

When Thomas Mott Osborne was president of our organization, a committee was appointed under the chairmanship of Helen Hartley Jenkins directed by our old friend Dr. Walter B. James, President of the New York Academy of Medicine and our beloved Thomas Salmon. An appeal to the Rockefellers brought the money and with Dr. White's blessings we financed Dr. Bernard Glueck's experiment at Sing Sing. The result was the commitment of New York State to building and equipping the classification institution at Sing Sing out of which the developments described by Dr. Branham and Dr. Baker have come. I always held in mind the advice of Walter James: "Whitin, beware of the factions in the psychiatric field." I want to see all groups represented on the staff at Sing Sing and force them to work together—let dog eat dog—then we will get somewhere. Fifteen years have passed, a substantial fund has been spent by research foundations and state governments. Last year we made a study to ascertain the

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**The text between dashes (— —) has been added by Dr. Karpman, October 1945.

value of the findings in the several states. Conscientious men had examined a great many prisoners and the records were on file. A method of classification was in vogue but there was need for a thorough analysis before this material could be made a basis for guiding the broad lines of even the building program which was under way in several states. It was obvious also that it was the exceptional administrator who could envision the opportunity of using the information for administrative purposes, and even this was retarded by technical terminology and a lack of technique in its application to therapy. Commissioner Ellis in New Jersey, The Lewisohn Commission in New York based their programs upon the work initiated by Colonel Sears, and a start was made toward rationalizing our building program.

At Toronto at the round table which was the forerunner of this meeting tonight, I asked you psychiatrists to tell us how to actually make use of this psychiatric work in the administration of the penal institutions. Your kind reception of my request led to a general discussion whch was followed by the volunteering of Dr. Jacob L. Moreno to give us a concrete answer. Moreno was a stranger to me, and I was surprised as well as pleased by his audacity in daring to come forward with an answer. His answer was put in writing. Experiments have been made at Sing Sing, in a public school in Brooklyn, The Riverdale Country Day School and at the New York State Training School for Girls under Moreno's direction. The basic philosophy has been discussed tonight, and this with a preliminary statement of technique together with the comments of those who have watched the development are contained in the monograph which is in your hands this evening. I personally do not pretend to pose as an authority on this contribution. It happens to be in accord with educational philosophy I learned under Dewey, Thorndike, and McMurray at Columbia. It harmonizes with my work in settlement groups in the experimental school I ran under Teachers College. It clicks with the intensive work I did with Osborne in self-government, but you are the authorities. We, of the National Committee on Prisons and Prison Labor, believe that after fifteen years, and the spending of a substantial sum of public money there should be an answer which can be made clear to the prison administrators. Moreno has made an honest attempt to give an answer. If this is not an answer, who has got one? Hundreds of thousands of men are being poured back into society from our institutions worse than when they went in. These disordered minds have developed a crime situation which threatens our civilization. Legis-

latures are curtailing their expenditures for government activity so as to
feed the starving.   The National Committee on Prisons and Prison Labor
wants to plead with the legislatures to continue their appropriations for
psychiatric service, and enlarge that service.   Is the expense of it at this
time when people are starving justified by the results?   You will pardon me
if I issue this challenge, but I remember how little is the profit from private
practice at this time, and how desirable it is, if only from a selfish pecuniary
standpoint that you help maintain and develop the opportunities for honest
service in the institutions which operate under our governmental budgets.

Dr. White, whose magnificent analysis of Moreno's proposal has
kindled in me a great hope, has consented to draw together a group which
will face this problem four-square, and I give way now to Dr. Moreno whom
I trust will lift us from the sordid realities to a more spiritual approach to
the opportunities which are afforded by his proposal.

DR. WHITE:

Now I will beg Dr. Moreno who is the originator of this group plan
to talk on the subject.   I am confident he will be able to answer all the
questions and to wind up the discussion to the satisfaction of all.

DR. JACOB L. MORENO:

It is a heavy load which Dr. White has put on my shoulders.   I do not
know how I can answer in a few moments what I have attempted to present
in a hundred-page monograph.   Unfortunately also, we are here not in
an institution or in a community, I cannot invite you to walk around with
me and see how the plan works, I am enclosed with you here within these
four walls.   It seems I have only words at my disposal.   But there is a way
out if you will not take any offense.   If you will allow me to use you your-
self, our own grouping, here and now, as material for diagnosis.   If you will
allow me to let my imagination run and describe you as if you were char-
acters in a play, then I may have to use fewer words and we will reach a
better understanding.   This method of *direct demonstration* has been often
used by Socrates.   He had to drink the hemlock for it; I hope you do not
mix a potion for me after you have heard what I have to say.

Let us then, Ladies and Gentlemen, look over our group here and see
what is characteristic about it at first glance.   This situation as a *per-
formance* was not prearranged.   It is like a spontaneity test.   Most of the
participants made up their minds only a few hours ago to attend this

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meeting and as it was to be a round table discussion, everybody was welcome to act in it. Nobody knew ahead how he would act in it and only a few knew before time that they might act in it. Even if we assume that the speeches of our participants could have been predicted were their individual equation fully known, the clashes of the attitude of one speaker with the attitude of other speakers and the products of these clashes are psychologically a novelty. This was, then, an "impromptu" situation with a common theme, the group method, and with a chosen leader, Dr. White.

But none, even Dr. White, knew what would happen and all were curious to watch how he would develop the dialogue back and forth. As no individual actor in this situation had prepared himself exactly how to meet it, many of the attitudes taken in speeches were produced on the spur of the moment and we could observe that they were more or less modified by the attitudes of the other speakers of the group. We saw the influence of the actual present constellation upon each of the persons here, irrespective of what his performance concerning the same theme would have been if he had been alone in his living room writing about it or discussing it in a different group with a different set of persons.

We have, for instance, a number of New Jersey men here. Definite and established minds, as Dr. Bixby and Dr. Doll, would perhaps have steadfastly repeated the same performance in every group, always inclined to take the opposite stand whereas the more flexible Dr. Holsopple might take the side of the underdog under all circumstances. But however independently each of them has been seen to act, there is an interrelation between their attitudes, even when they contrast, which melts them into an intellectual gang.

There are, too, a number of distinguished ladies in the group. Did it not seem also to you that they had a reaction in common, rather in favor of the group plan? Is it sympathy for an innovator who has to overcome repulsion and resistance? Or is it due to their sitting around the same table, influencing each other?

As "leader" of this group and moderator of the discussion had been chosen Dr. William A. White from Washington. The fact that this is by far the best attended round table of the annual convention of the American Psychiatric Association demonstrates that a great number chose spontaneously to be in the group in which he "leads." Certainly for many of them ·the theme under discussion has been of secondary consideration. Dr. White has the prestige of a good abbot, he has "fatherly" qualities. He has a

gift of balancing one against the other. Then, too, it may be said he is superior in strategic intelligence and experience in debating to all, perhaps, who have contributed to the discussion. Does he not fit into the qualification we demanded from a leader? If we affirm this, then we come to consider what effect his behavior during the discussion had upon the various speakers who participated in it and upon the performances as a totality. First of all he enforced a level of dignity and moderation of attitude the absence of which would have led to a total failure of the discussion which centered about a most difficult topic. He prevented ridicule which so often finishes attempts of pioneering. The strength of Dr. White's presence has been felt by all.

Let us imagine how different the performance would have been if instead of Dr. White another man, for instance, Dr. Karpman, had been chosen as moderator. I believe that almost every one of the twenty-five speeches would have been different in content. Perhaps many who did speak would not have spoken at all, and others who have been silent this time would have rebelled. It might have come to clashes and to a sudden breaking up of the discussion. A different picture might have resulted if Dr. E. Stagg Whitin had been chosen as moderator. The discussion would have become a cross section of correctional endeavor in the United States and have run off into prison industries, his favorite topic. Thus the prison men of the group would have come into the limelight and the psychiatrists would have been pushed aside. Still less wise would have been the choice of myself as moderator. The number of participants would have been small and the round table would have become a dramatic clash between group psychotherapy and psychoanalysis.

These imaginary effects would not be due, as we have found in many studies of group structure, to the make-up of personalities in question alone, but largely to the position they occupy within the structure of the group present. This "position" is not determined by their wishes and abilities only but it is determined by the sympathies and antipathies of all other members of the group. Of some of these influences a member of a group might be aware and of others he might be fully unaware. This is true even of an improvised group formation as ours is, largely because many of the participants have affected each other either through personal acquaintance or by indirection. If we should try to state the attitudes of sympathy, antipathy, indifference—and of the deeper emotions underlying them—each has towards each other person of this group, we would find a very curious

crisscross, revealing by close investigation the position and the influence of each person. It may show Dr. White as receiving sympathy from the largest number and thus we see how fortunate it was that Dr. White was won to function as moderator. The ladies who were so excellently represented by Mrs. Morse, Miss Jaffray, Mrs. White, Miss Jennings, Dr. Potter, Mrs. Johnson, might have received little or no opportunity to speak if we had a moderator less gallant. Again it may reveal others as having the position of the isolated or of solitaires. The study would also show doubtless many mutual-friends-structures, pairs who have a special intimate relationship due to common scientific interests as the two psychoanalysts, Dr. Alexander and Dr. Lorand. It may disclose a surprising number of structures including three or more persons set off from the larger assembly, such as, for instance, the Public Health group.

Last, not least, we find—besides most desired individuals, solitaires, mutual pairs, dissatisfied aggressives, gangs etc.,—still another condition which illustrates the psychology of grouping. There is an individual here who is in a similar situation to that of Dr. White, only in the opposite sense. He is also a center, but he may be the center of resentments and repulsions, not of attractions. He is undesired like a solitaire, but he has a certain distinction: he is the prototype of the unwanted individual who attempts to impose something upon a group that is by its very nature critical and suspicious towards him as towards anyone who assumes authority before the reason for it is fully demonstrated. This person is, as you may have already guessed, myself.

Of course, to make a special research of this status nascendi group, arrangements should be made so that its participants could live together for a period. New factors will then come into effect and consequently new interrelation will be established. In time, due to living together, face to face, the picture of the group structure might change considerably from the present. Of influence may become the fact that some men have studied at the same university or have practiced in the same hospital or have founded coteries together due to common scientific, political, social or religious interests. However, perhaps, the most persuasive demonstration of the group method would be if all the members of this group would volunteer to stand a sentence of one year in one of our prisons. Let us form a "Therapeutic Society." Many maladies have been studied with success by physicians through experimentation upon themselves. Why not apply this same principle to the problem of group therapeutic organization?

A teacher greater than Socrates has given us an indication how this can be accomplished, the originator of the Christian monastery, Jesus of Nazareth. Indeed, the group of men and women around him is the matrix of the later monastery and far more astounding than the miracles is the manner in which he penetrated situations and prompted conversions and cures in the midst of social actuality. Intuitively recognizing the position each person had in a group, he played one against the other to produce effect where it was least expected. He treated Judas in arguing with Peter, Martha through Mary, the Pharisees through Magdalen. Indeed, the monastery was in its origin an attempt to "improve" society, a sample of a new social order, more characteristic for christian pioneering than the church. It was some sort of group-healing, one man correcting and inspiring the other, a correctional institution.

The family structure is rigid, parents are bound to each other, children to them and to one another by natural laws. Parents and children cannot be taken out from one family and transferred to another. But the monastery is free from natural bonds. It is exactly here where the Christian monastery in its attempt to place together individuals of the most varied backgrounds to form "synthetic" families was driven to ingenious methods of grouping. Two distinct movements can be distinguished in the development of the monastery. The one type can be called the individualistic type of monastery, flourishing particularly in Egypt and Syria during the first centuries of our calendar. It was an attempt at cure, through solitary means only, barring as a vehicle of development the value of attractions and repulsions which happen to the individual in a group association. It represents an attempt in the spontaneous, activistic direction, and it is a strictly individual-centered procedure. This kind of monastery gave way gradually to the "'coenobitic," group-centered type of monastery. The solitaire way to sainthood, helpful to a few outstanding individuals only, proved a failure to the large number of monks who develop better in an organization which provides, besides the training in solitude, the training through friction with other individuals which was most excellently demonstrated in the rule of St. Benedict. The head of the monastery was the abbot, meaning father. To make as intimate a contact between the abbot and his monks as exists between father and children of a family, he suggested the monastery to be small in number and asked that it be subdivided in small units of about twenty members, each of them to be headed by an abbot substitute. We see here the notions of the leader and the small contact group evolving.

But when he transferred an unbearable monk from one monastery to another the seed of sociometric assignment was already planted. The shifting of men from one group to another was possible within the monastic organization due to its spiritual make-up and this is an advantage it had compared with the family to which the members are permanently attached by an order of nature.

But is it possible to go beyond these symbols and metaphors and to develop an exact science of group organization, a "sociometry"? Our experiments have shown conclusively that this can be accomplished, if first of all, methods are discovered which make a quantitative and qualitative analysis of groups possible. These methods are being studied in the New York State Training School for Girls at Hudson. They are, although still in the process of development, of reliable accuracy. Once the quantitative and qualitative composition of the groups which a community consists of is known, the foundations for a scientific group psychotherapy are laid. Then the question arises: how is it possible to reshape and correct groups whose inner organization is found to be deficient?

Through techniques of reorganization, assignment, retraining and other methods of group manipulation which assist each member of the community in finding for himself the most desirable place, the abodes of the unfortunates, correctional institutions and training schools, may bring about for our time what the monastery accomplished for its age, a renaissance of society.

GROUP PSYCHOTHERAPY

A Round Table Conference at the One Hundredth Annual Meeting of
the American Psychiatric Association, Philadelphia, Pa., May 16, 1944

CHAIRMAN, DR. ROSCOE W. HALL

Discussants: Drs. Nathan W. Ackerman, Lauretta Bender, Comdr. Francis J.
Braceland (MC) USNR, Lt. Col. R. Robert Cohen M.C. (by invitation),
Drs. Maxwell Gitelson, Samuel B. Hadden, Lt. Comdr. Herbert Harris (MC)
USNR (by invitation), Frances Herriott (by invitation), Drs. Abraham A.
Low, Jacob L. Moreno, Maj. Samuel Paster, M.C., Stephen Sherman, P.A. Surg.,
U.S.P.H.S. (by invitation), Bruno Solby, Surg. (R) U.S.P.H.S., Drs. Alfred P.
Solomon and Louis Wender

ROSCOE W. HALL, M.D.

Saint Elizabeths Hospital, Washington, D. C.

INTRODUCTORY REMARKS

A number of years ago in a preface to some book, Dr. Adolf Meyer
wrote, "Hospitals are attempts at mass treatment, gradually working their
way back to the individual patient." In a sense, group psychotherapy has
been used for generations in mental hospitals. In his book "Administrative
Psychiatry", published in 1936, Dr. William A. Bryan has a lengthy chapter
on the subject. In *Psychosomatic Medicine,* April 1943, Dr. Giles W.
Thomas, unfortunately since dead, published a very worthwhile review of
the literature on the subject. His review was comprehensive and at least
attempted to be critical. Unfortunately, in several instances he was depend-
ent entirely on the publications of the authors and it was another instance
of the importance of "who said what?" as well as "what was said?" I do
not mean to stress the importance of "authority" because "authority's"
foot can slip on occasion, but to call attention to the fact that at times
printed words may give no indication of the worth, or lack of it, of their
content.

On one occasion in commenting on Count Alfred Korzybski's work
Dr. William A. White said, "I do not know what it is all about but I
believe that he has something by the tail." I feel somewhat the same way
about group psychotherapy. The psychoses and psychoneuroses present
psychotherapeutic problems along two main lines—adaptation and insight;
and while the latter is highly desirable, the former, that is, adaptation, is
more essential. We have all seen patients make surprisingly good improve-

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ment or recovery with no evident insight, and, conversely, there is no more pathetic sight than that of a patient who can glibly describe his conflicts, complexes and make-up, perhaps in psychoanalytic terms, but who is unwilling to make any better adaptation than occupying a ward or park bench. The goal of psychotherapy is a combination of these two lines, adaptation and insight. It is the release of energy that is bound by internal conflict and interest and the intelligent direction of all available affective energy to channels that lead to more healthy social adaptation. The process of psychotherapy might be described as an affect-mobilization (transference). Presumably group psychotherapy lays more stress on insight but it seems to me that no less stress should be laid on adaptation, and group work can be made peculiarly useful to this end. It is in a larval and heterogeneous state at present but it seems to have abundant vitality and to be arousing increasing interest. When the organization of this so-called round table was wished on me, even at the risk of diversity and bulkiness it seemed desirable to have various aspects presented and hence we have speakers on prevention, on children, on psychodrama and on group psychotherapy as most of us recognize it.

A pertinent question deals with the special characteristics, if any, of the group therapist. There have been a number of articles on the subject of group therapy in the British medical journals and apparently the interest in it has been based mainly on the need for treatment of larger numbers of individuals and the paucity of physicians. Dr. Frank Fremont-Smith through the Macy Foundation has done a very useful job in distributing copies of these British papers to our medical service personnel. In this country the same need has existed to some extent but also there have been a number of physicians who have interested themselves in group work because they do better with groups than with individuals and are of the "hire a hall" type. Psychiatrically they might be described as hypomanic extroverts and "proceed with caution" means little to them. For the more unvocal physicians I am wondering about the possibility of the use of a recording on the various subjects that almost uniformly come up in group discussions. Despite our emphasis on "rugged individualism", it seems to me that group psychotherapy should find a particularly fertile soil in the United States with its penchant for conformity, experience meetings and Chautauquas.

Captain A. A. Marsteller of the Naval Medical Corps, recently returned from the South Pacific, told me that he came in contact with no organized

group psychotherapy but that he had seen a number of instances where at morning sick call the symptoms of one individual were discussed before the other complainants, and the effect was at least to diminish subsequent attendance. Also he told of a number of physicians with psychiatric interest who would conduct informal talks about common personal problems with patients on the wards.

The question of nomenclature does not seem to me to be too important at this stage of development, although I can appreciate the point that group psychotherapy should be limited to that in which physicians participate. At the same time there are a number of group therapeutic activities in which the physician can function best by being absent but not necessarily an inaudible member. For instance, in many mental hospitals the Red Cross can offer a neutral outlet for the patients to discuss common problems and blow off steam, even against the hospital—and sometimes it is not all steam. Useful therapy, under guidance. I suppose we will have a problem with lay group therapists such as the psychoanalysts, psychologists and social workers have had, but Miss Herriott's presentation is an example of how useful an intelligent, understanding and experienced lay person can be. As an aside and apart, Alcoholics Anonymous has a better batting average than any medical group with which I happen to be familiar. And I believe I am also echoing the opinion of Dr. Lawrence Kolb, former Assistant Surgeon General of the United States Public Health Service.

There are also some workers who do not believe that group psychotherapy, aside from psychodrama, is of use to psychotic patients. Without being a group enthusiast, I do not agree with this. Some of the earliest group therapy work reported was on psychotic patients. More important, a large proportion of psychotic patients tend to be asocial and to individualize themselves to a pathological degree. Group therapy here is not only of theoretical but of practical value.

Levy-Bruhl and Storch have emphasized the pathological implications of "participation". This factor may have its uses, too, in group therapy—just, as Dr. Meyer has pointed out, the catatonic reaction may have in the individual patient, when we know more about it.

In treating the psychoses and psychoneuroses we know the importance of having the patient take an objective attitude towards his problems and symptoms. Group psychotherapy should be particularly useful in the development of objectivity.

A major contribution of psychoanalysis has been the elucidation of

the patient-physician relationship. Perhaps similarly, the development of group psychotherapy, which admittedly is finding itself at present, may give us useful information about the individual in relation to the group, the physician in relation to the group, and the members of the group in relation to each other.

GROUP PSYCHOTHERAPY

CAPTAIN FRANCIS J. BRACELAND, (MC), USNR*
Chief, Neuropsychiatric Branch

My function in this program tonight is to introduce the subject of group psychotherapy as it relates to the military, and particularly to the Naval, Service. Due to the limitations of time, this presentation of necessity will be sketchy, and I shall rely on my confreres who follow me to fill in the details and elaborate upon the theses which I can merely present for your consideration.

Military group psychotherapy (1) as it is practiced today bears only a slight resemblance to the group psychotherapy heretofore practiced in civilian life. Born of necessity and used as an expedient in the early days of the war, it has come into its own through the use of various innovations and expansions as a technique for the treatment on a group scale of the psychological casualties of modern warfare. The goal of group psychotherapy in military service is clear-cut and definite even if, when compared with civilian group methods, it appears limited in scope. The primary purpose of the military therapist is to get the patient well enough to return to full combat duty. Failing in that, it is incumbent upon him to try to return the patient at least to his pre-enlistment status so that he may re-enter civilian life as an independent and self-sustaining citizen.

On the other hand, viewed from a technical standpoint, there are important basic meeting points between military and civilian group psychotherapy which merit attention. Such phenomena as the patient-doctor relationships are common to every group. The manner in which certain psychopathological reactions are interpreted and explained collectively is comparable in either setting. Also the laws which govern group actions, cohesion, and stratification are applicable to all groups. Whether the lessons learned in military group psychotherapy will be applicable to the markedly dissimilar situations which will be encountered in post-war civilian practice remains to be seen.

I have stated that group psychotherapy in the military service was

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*The opinions and assertions contained herein are the private ones of the author and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service as a whole.

originally used as an expedient. This implies a negative causality for its use and hence is not sufficient cause for the continuation of a therapeutic method once the emergency has been met. The question arises as to whether the psychiatric emergency ever has been met or ever will be met. Pre-war psychiatric therapy was available to only a selected few patients. It was time-consuming and difficult and consequently capable workers were few and but very few patients were treated—the majority received no care. Most military psychiatrists, equipped only with established civilian techniques, soon found themselves faced with demands which they were unable to meet.

There was another fact which impressed itself upon the medical officers, however, and that was the powerful influence and unifying quality of mutual adversity. Men who have experienced numerous adventures and hardships and have lived intimately with groups of comrades develop a feeling of security and "belongingness" as members of a group. Here was an opportunity for group psychotherapy to capitalize on this sameness of experience and to unite a technique of expedience with one of election.

It would be interesting, therefore, to contemplate for a moment the other factors which have operated to give impetus to the relatively wide-spread use of group therapeutic methods at this particular time. Heretofore psychiatry has been concerned almost entirely with the activities of the individual. With extreme care and brilliant thoroughness, it has dissected the various psychologic reactions of individuals under stress and utilized the knowledge gained in various therapeutic methods. Rightly, it has considered every patient as an individual, but the deficiency has been that sometimes it has paid only lip service to the fact that individuals with or without symptoms must live in a world composed of other individuals and groups and influence, and be influenced by them. Not infrequently therapists were confronted with the fact that patients who apparently had recovered and gained insight while under treatment in sanitaria, relapsed shortly after their return to their normal social milieu.

One answer to this phenomenon undoubtedly lies in the fact that no person is an island apart from the mainland of social relationships. There are for all persons points of mutual contacts and common meeting grounds in which they must encounter their fellowmen. No matter how well integrated the individual may appear to be, the fact remains that unless he can take his place in the group or society in which he lives he will inevitably develop psychologic symptoms which will indicate maladaptation. At the

present time under the military system, close relationship with one's fellow-men is forced upon the individual; he has no choice. Just as war makes bedfellows of various nations, which must unite for a common cause, so also does it require individuals to unite with others to form groups in order to give battle to the common enemy. Thus, military service provides a natural, ready-made setting which encourages and invites the trial of group psychotherapy.

In the first place, military patients have a great deal in common in being all members of the military service. They have lived, trained, played, travelled, and fought together and their presence in military hospitals for the purpose of obtaining psychiatric treatment indicates that they have developed their presenting symptoms as a sequel to, or concomitant with, their military experiences. Here then is presented an ideal, controlled situation for the trial of all forms of group therapy. The usual complicating economic and disciplinary factors which sometimes interfere with civilian attempts at controlled therapy are absent, for our patients can be kept under treatment as long as the military situation permits and during treatment they need not be concerned with the costs of medical care. These factors, plus the apparent generalized growth in interest in social and group problems, present us with an ideal opportunity to examine the possibilities and the deficiencies inherent in group therapeutic methods.

One thing is understood at the start by the proponents of military group psychotherapy, namely that its advocacy does not mean that the treatment of individuals can be reduced to the level of stereotyped standardized uniformity. As much specificity as possible in the form of individual interviews which supplement group therapy is, of course, desirable for the patients under treatment. All that military group treatment hopes to accomplish is to help each participant to define his emotional stability in terms of the norms or values of his particular social and economic group. Man adjusts or fails of adjustment and is stable or unstable not in a vacuum but by reference to the specific values which his culture and immediate group prescribe. Complete recovery in military medicine entails a return to full combat duty—a return to the situation which was responsible or which was the exciting factor in the appearance of neurotic symptoms. Failing in this, the military psychiatrist will settle for less, for it is recognized that the return of an individual to civilian life as a functioning member of society is an equally highly desirable aim.

Group therapy sets out to accomplish its purpose not only by making analyses of the nature of the deviations which concern the individual but it also attempts to accomplish a successful synthesis, both psychological and sociological. This attempt is made by approach to the patients through their points of similarity, similarity of experiences, similarity of symptoms, similarity of purpose. It presents material of common interest and of generic validity to the group in order that each individual may participate and personalize the more or less universal concepts which are set forth. It seeks to utilize concepts which are readily recognized by the participants and, while attempting to correct aberrant tendencies, aims to direct the individual to the goal of normality, sometimes openly, sometimes subtly.

Inasmuch as military group psychotherapy is an over-all education for social existence, a "round the clock" program is arranged on a twenty-four hour a day basis in an attempt to prevent the patient from regressing to an attitude of personal isolationism. Athletic, recreational and a masculinized form of occupational therapy are utilized as adjunct therapies to attain this end. Teamwork is stressed for it is symbolic of the attitude which will be required when the patient leaves the hospital.

The Navy has found that audio-visual aids, particularly films which subtly indicate that some psychological and physiological reactions are common to all men, are of great value. Commander Rome (2) is collaborating in the preparation of a library of special treatment films (3) which will considerably amplify the therapist's resources, as well as relieve the group sessions of any danger of monotony. Thus far five films have been completed, and a study of the patients' reactions to them has been undertaken.

Finally and in the last analysis, the success or failure of group psychotherapy depends upon the therapist. The function of the therapist is to act as a moderator or as a screen upon which the group can project its own reactions. Any tendency toward delivering a monologue or a lecture must be carefully avoided. The moderator must be alert to see that one extravert does not monopolize the session and that no introvert, though physically present, psychologically isolates himself. The approach to psychological reactions must be on a generic basis and the formation of symptoms clearly and logically explained. If the moderator persists in translating the knowledge he gained in the practice of individual psychotherapy to group therapy with no regard for the psychological reactions and motivations of groups, he will attain but minimal success.

In closing, may I add that Naval psychiatrists make no untoward claims as to the value of group psychotherapy, nor do they regard it as a panacea. It is simply another valuable weapon in the psychiatric armamentarium of the medical officer.

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GROUP PSYCHOTHERAPY AND THE PSYCHODRAMATIC METHOD

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Both advocates and sceptics of group psychotherapy have ascribed the development of this therapeutic method to the increasing need for psychotherapy and the present dearth in trained psychiatrists to satisfy the demands for psychiatric services. This mechanistic interpretation, which ascribes the development of a new method to the dynamics of supply and demand, disregards the economic law which states that whenever the supply of certain goods or services is insufficient to meet the demands for them, the substitute product or service is not one chosen at random but represents a manifestation of new discoveries, of new orientations, which had remained latent up to this time.

Does group psychotherapy offer a technique of practice based upon an emergent theory, a new theory of man's mind in health and disease? It is our conviction that it does. For concomitantly with a growing interest in group psychotherapy we observe also, to an ever increasing degree, reformulations of principles in psychology which explain man's psychodynamics in terms of his interaction pattern with the other members of the group. The original psychoanalytic theory of man's mentation as a superstructure imposed upon the biological organism in struggle with society has ceded ground to ego-psychology and the concept of basic personality structure. Though lip-service has been rendered to various "social" theories of man, the basic orientation continued to be rooted in biological principles. Thus, those who advocate or even practice group psychotherapy have not necessarily changed their primary orientation. The contradictory reports as to methods used and results achieved are no doubt to be attributed to this discrepancy between theory and practice.

Group psychotherapy is *always "group" therapy*. It is the group itself that becomes the therapeutic agent as a result of the interaction between the individuals who form the group. The psychiatrist who does not recognize the therapeutic dynamics inherent in the interaction between the individuals forming a group has missed the boat. For, guided by biological principles, he essentially distrusts the group and uses the group as a sub-

stitute tool for the achievement of the therapeutic goal, by conceding to the group the status of the herd whose libidinous attachment to the leader (father, psychiatrist) is partly transferred to each member of the group. This type of group therapy can be observed in many cults and "healing" meetings. I have always been inclined to believe that only fear of either latent or objectively observable dangers has induced individuals to subject themselves to this primitive relationship. The leader of such a group usually utilizes this fear and confusion of its members for his own end, whether it be monetary gain, power or some other advantage he expects to accrue. In this group structure the leader of the group assumes the healing function. We hardly can call this procedure group therapy.

For group therapy should be understood as the psychotherapeutic process which results from group interaction. The functions of the psychiatrist therein are twofold: He controls by specific methods the degree of spontaneity of the interaction process and, secondly, he acts as a catalyst, in the interpretation of the group to the individual or of the individual to the group. Such orientation implies that the psychiatrist, in the course of his education and training, will have acquired a knowledge of social dynamics in addition to his training in psycho-dynamics. There are many indications that this course is followed by an increasing number of students.

It is lack of this knowledge of the dynamics of the group that at present limits the extent of this new therapeutic procedure.

Up to the present, aside from group psychotherapy as practised in closed institutions, the selection of patients for this procedure has mostly been based upon some kind of identity which existed between the individuals forming the psychotherapeutic group. Various reports indicate that the following three categories of identity between individuals have been used: either the *identity of symptoms,* such as we find in psychosomatic disorders (and the majority of reports cover disorders of the gastrointestinal tract); or the *identity of social status,* which explains why attempts in group therapy have been reported so frequently from the Army and Navy; or, finally, the *identity of a formulated goal,* as we observe it in religion—especially in its institutionalized form. The results of these therapeutic attempts appear to be proportionate to the degree of identity achieved in the individuals selected to participate in the procedure. This screening process in the choice of patients represents a limitation which might well be caused by the lack of adequate knowledge of the inherent dynamics of group action.

As far as methodology is concerned we should like to advance the criticism that the methods of verbalization and intellectualization—to which group psychotherapy is often limited—do not seem adequate if group therapy is to offer a technique for treating individuals who cannot be benefited by the interview method. For verbalization and intellectualization would proceed better under the immediate direction of an expert than when left to the indiscriminate use by the group. Verbalization as well as intellectualization means the employment of socially significant symbols. But the emotionally and mentally ill attribute to symbols a very personal and private meaning. The method therefore, if it should offer us advantage over those in use up to the present, should include means of communication that might be described as pre-verbal and which we find represented in gestures or non-verbal action patterns. These, too, often represent symbols, also socially significant, and could help the individual to communicate himself to the others and thus to transcend his isolation. With children play therapy has been used for this purpose; for adult patients we see in the psychodrama the method which adds meaningful action to communication on the verbal level.

The use of the psychodramatic method in group therapy will be described to you by the other speakers. I should like to discuss with you briefly the application of this method in a training program for personnel workers, such as employee counselors, placement officers and so on, in government departments where a more scientific approach to personnel problems was demanded.

In lectures to them on psychology we presented the role as a concept both sociologically and psychologically valid, and developed this theory to explain action patterns, especially the interaction patterns between the individual and the group. We also attempted in these lectures to relate pathological behavior forms, as well as their etiology, to various role patterns.

In connection with these lectures I felt, however, that some type of psychological laboratory practice would be of value in demonstrating performance patterns. The technique used was Moreno's psychodrama, in which various roles as they manifest themselves in specific situations were acted out; group discussions followed in which the psychological and sociological aspects of the performance were analyzed. We also demonstrated the emergence of a rigid role, as well as its interference with the execution of assignments. It was stressed that the industrial act takes place between the employee and the supervisor and that personnel workers function in an

advisory capacity only. This implies that their function is mainly catalytic and has to be based upon a thorough understanding of the situations that arise between the employee and his supervisor; their grasp of such situations was tested by their ability to take the roles of the employee and also those of the supervisor. Factors which interfered with their acquittal of occupational duties became apparent in such laboratory demonstrations and the group discussions which followed.

The results of the program have been very encouraging. They might be described as: better understanding by personnel workers of their responsibilities as well as of their personal problems; improved analysis and comprehension of employees' problems; more adequate selection of employees who need mental hygiene guidance and referral to our clinic. Emphasis in these lectures and demonstrations was not only upon the demands made by the employer—in this case, the Federal Government—but was more broadly related to the demands imposed by our industrial society, with its socio-economic and cultural patterns.

Though offered as a laboratory practice it undoubtedly had very definite therapeutic implications which were reported by a number of members of the group as a feeling of "loosening up" and the experience of improved interpersonal relationships; they ascribed this to an increased feeling of spontaneity and a re-evaluation of their performance on the job. Yet undoubtedly it was the ultimate performance on the job, in the actual job situation, which represented the final phase of the therapeutic procedure. This result represents also the limitation of every psychotherapy, whether it be group or individual. For I have never claimed that my patients recovered either in my office or on the psychodramatic stage, but have believed that the therapy enabled them to participate in the social act of the group of which they were members and that as a result of such participation they achieved mental health.

SOME USES OF PSYCHODRAMA AT ST. ELIZABETHS HOSPITAL

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For over three years Psychodrama has been among the various forms of psychotherapy in St. Elizabeths Hospital. It is carried on by the joint efforts of the hospital and the American Red Cross and has been found very effective in dealing with some of the problems of the *about-to-be-discharged-service-patients* and their return into civilian life.

Patients are selected for psychodramatic treatment by the physicians (or social workers or patients, with the approval of the doctors). They come to the theatre and, with the guidance of the director and staff, act out situations dealing with interpersonal relations and social problems. These scenes are "spontaneous and unrehearsed," but each one is carefully planned to fit the needs and interests of the participants. The audience is made up of patients, Red Cross helpers who are trained in psychodramatic techniques, occasionally physicians and psychiatric social workers.

In an informal and friendly atmosphere on a circular stage especially designed for this work, family, hospital, service and re-employment problems are presented. Each scene is usually followed by a vigorous discussion.

At the time patients are referred, they usually feel very insecure and are emotionally unstable. From their case histories we know that many of them have gone through very harrowing experiences, while others, even before any actual combat, have not been able to meet or adjust to the demands of military life. After a breakdown of this nature they are often afraid to encounter ordinary everyday situations and they feel they are "failures." With Psychodrama we try to help them regain their self-confidence and to strengthen their faith in their own abilities.

To begin with very simple situations are chosen, such as going to a grocery store. A few tables and chairs are arranged to suggest a counter in the store; a staff worker— or another patient who may volunteer—becomes the clerk and the scene begins. Always the patient must be carefully watched to see that things do not get too much for him. He *must not fail* during his first few scenes on the psychodramatic stage. If he shows any signs of floundering someone must go in and support him. Only situations which he can *successfully* bring to a conclusion must be tried. Later on, when he feels more sure of himself and seems ready to meet more diffi-

cult situations—perhaps even competition—he can be presented with more involved scenes.

One of the problems, which seems to be most common among the convalescent service patients, is: "What am I going to tell people when I get home—how can I explain being out of uniform with the war still going on—if I had lost a leg or something!" In a short interview with a patient, John Doe, we learn that his "family will understand" for they have visited the hospital, but the "nosey neighbors will want to know *why* I am out of service and *at home*." We suggest a scene in his home town, at the Post Office where his mother has sent him to mail a package. While the patient is involved with the business of mailing the package, a staff worker in the rôle of the "nosey neighbor" enters suddenly upon the scene and addresses the patient *by name*. "Why, aren't you John Doe?—I didn't recognize you at first—I thought you were in the Navy.—Are you home on leave?" There are innumerable ways of meeting and answering this inquiry, depending on the relationship of the person who puts the question to the patient. He may reply that he has been discharged from the service (honorable discharge) and is now "just at home"; or (if pushed by the staff member) he may tell of his breakdown, his hospitalization and recovery. One particular John Doe folded up when confronted by this question and it was several sessions before he could make an adequate response. Such scenes usually lead into a general discussion among the patients in the audience, and many fears are ventilated as the patients discover that their worries are shared by others. On one occasion a patient remarked that he would tell people that it was "none of their business" why he was at home, so we gave him an opportunity to do just that. The scene was in the drug-store, and as the soda clerk (a patient or staff member) was polishing a glass, he asked," How come you're not in uniform?" The patient turned to give his retort and found that it was more difficult than he thought to reply, "it's none of your business," thus learning from *actual experience* that there were perhaps better ways of solving his problem. In reality each individual will have to deal with this situation for himself when the time comes, but in preparation for that moment, he can, in the theatre on a spontaneous level, rehearse for real life—or watch others meet similar situations—or,—by reversing the rôles, to get a grasp of his situation as a whole,—he can play one of the people "back home."

Another type of scene we have found helpful to patients who are about to leave the hospital are those dealing with employment. In some instances

a detailed description of the nature of the illness, or reason for discharge, may be necessary. We set up an employment or personnel office. Usually a receptionist meets the applicant (a patient), inquires his reasons for coming in, and directs him to the office. In the employment interview, new vocational interests often come to light and are discussed freely. If we have anyone in our audience who has specific knowledge of a particular vocation mentioned we can use him as the interviewer.

On one occasion, a young sailor with only a high school education and a few months service in the navy said he would like to work in an electrical engineering firm. When challenged as to the likelihood of his getting a job with his lack of training, he said that he could be a "blue-print boy" and take a course of training while working. At that session there was in the audience a patient who had never played a rôle on the stage, an officer who was a graduate from a mechanical engineering school in a big university. This officer was asked if he would take the rôle of the personnel manager of a big electric plant and interview the applicant. He agreed and went up on the stage; the boy entered and the interview began. Questions of training—experience—salary—living quarters and draft status were discussed. It was a very real scene—the interest growing as the scene progressed. The straightforward manner in which the boy explained that he was 4-F because of a medical discharge from the service did much to convince the "personnel manager" of his recovery and his present ability to start out again in a civilian job. When the scene was over the boy came off the stage with a feeling of accomplishment. The officer, too, was benefited for he felt he had shown himself as a person of importance, not a "failure." This brought stimulus to both of them; their shyness disappeared and an eagerness to tackle further scenes was aroused.

The case of Mary Doe, a Navy Nurse with 17 months' duty before her hospitalization illustrates another angle of this same problem and how it was worked out in psychodrama.

Mary was worried about being able to get a position as a nurse in a hospital after her discharge from St. Elizabeths. "Everybody knows what kind of hospital St. Elizabeths is—!" We made up scenes in which Mary applied for jobs other than in the nursing profession; scenes in which Mary as an office nurse had to see an applicant for the job of telephone operator, and during the interview the applicant revealed the fact that she had re-recently been discharged from a mental hospital; Mary applying for a job in a hospital and being questioned concerning her training, experience and

reason for leaving her most recent position; and then Mary in the rôle of a Superintendent of Nurses, confronted with numerous problems, including seeing a young woman (staff member in the rôle of *Mary*) who has come to apply for a position. In this last scene, Mary listened to the applicant's story (her own), hesitated, and then inquired whether the applicant felt fully recovered and able to resume work. On receiving an affirmative answer, Mary decided to give her a try. Two months elapsed after Mary's discharge from St. Elizabeths when we received the following letter: "I know you will be interested in how the 'situation' was presented and met. It wasn't so bad—I had to fill out the application blanks and answer questions just like the scenes on the stage, and I am ever so grateful to you and Miss Pié for all the rehearsals. They really fortified me for the occasion. I want you all to know that your work and effort was not in vain." This letter was augmented by another, six months later, to report all was going well with her; she was working in the same hospital and enjoying life in her new surroundings.

The fields in which Psychodrama and its various techniques may be of value are many. As a form of treatment combining group therapy with Drama it is extremely flexible for it can be adapted to almost any social and age level. It is probably a little early to make any statements about the lasting effects of this form of group treatment, but from the many letters received from former patients, we know that Psychodrama has been helpful.

PSYCHODRAMA IN A CHILD GUIDANCE CLINIC

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Psychodrama was started at Duke University Hospital in 1943 and the following will illustrate some of its applications. Patients who are admitted to the psychiatric service, whose post-hospitalization plans might be aided by psychodrama are given over to the dramatist for the last few days of their hospital stay. Through the media of an actual stage, trained helpers, or by means of a dramatic interview technique, their problems are worked upon and the patients are enabled to return to their environment with more security.

A questionnaire has been devised, called a psychodramatic social history, which is made up of situational questions used at the discretion of the psychiatrist to bring about a procedure of rapid rehabilitation of the patient's practical and conscious problems. It is from the result of this questionnaire that the situations the patient acts out in his psychodramatic course are derived. The major portion of the writer's work with psychodrama was carried out in the Child Guidance Clinic connected with the Department of Neuropsychiatry. This paper for the most part will be written around psychodramatics with children.

The value of play technique in the treatment of childhood behavior disorders is well known to the psychiatric field. However, psychodrama has another advantage. Having only the child's imagination and problems as props, it is a simple matter to put his problems on a reality level, thus offering him active treatment from the time of his first clinic visit. In bringing into play this unique quality of spontaneity, the patient is revealed to himself and helps remove the need for self-deception. It is a dynamic inter-play of the interpersonal relationship, which the child can accept for himself as truth, because it is himself in action. This freedom of action was not granted to children until recently; the child was brought to the Child Guidance Clinic, tested, measured, and questioned but was given little opportunity to express himself in his own way through the medium of play. This method provides a wealth of general material within a brief space of time, and has the advantage of allowing the psychiatrist to treat the child and his problems immediately rather than having to wait until rapport is established to develop the treatment through the medium of direct conversation. All children dramatize in their play their inner needs,

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compulsions, and interests. Spontaneous play centers around those life activities which they have most recently observed, those which have made the most vivid impression upon their young minds, and those with which for some reason they happen to be concerned at the moment. Play habits have too important an effect upon a child's subsequent development to be allowed to develop entirely undirected, and although a child's play should not be adult-dominated, it can, through the wise use of psychodramatics, be guided along lines which have definite benefit to the child and his future adjustment. Therefore we may assume dramatic activity is merely the outward manifestation of the child's innermost thoughts and fantasies. Basic neurotic traits are expressed when the child is free to engage in spontaneous play, and an experienced observer can obtain much information regarding the mental health of the child simply by studying the child's spontaneous play activity.

It is our purpose in psychodrama to discover conflicts in children who are preoccupied in any one form of activity or thinking, and through such discovery, to give them all possible help in enabling them to free themselves of any conflicts, thus helping them to advance more wholesome interests. We do not intend to increase the child's neurotic behavior by encouraging those play activities that tend to aggravate the original disturbance, but rather to direct his activity to a more normal and outward channel. Dramatic play that is motivated by neurotic thinking can be directed so that it will lead to a solution of the emotional problem through encouraging wholesome play activities, which, at the same time, are socially acceptable to the group in which the child has to live. A very important thing to remember is that children need help and protection against over-stimulation and that they should not be encouraged in their preoccupations. A wise use of psychodramatics can do this.

Whether or not a child is to be treated by psychodramatics is based largely upon the psychiatrist's interview. Results of psychological tests and the individual child's needs play an important part in determining whether this method should be utilized. If psychodrama is the method of choice, the child is started in a group which is suitable to his needs, or is left to the dramatist alone, depending upon the nature of his conflict and problems. The child is afterwards put through a series of situations suited to bring out the core of his problems. These standard situations cover the entire gamut of his interpersonal relationships to his family, to his friends, and to society in general.

In choosing a group of standard situations which could meet the needs of every child and are not too time consuming, all the important aspects of a child's life are considered. It is very important to know the measure of a child's fantasy life. This is accomplished by means of fairy tales and games, because in these activities children very often show their opinions and problems, giving the therapist a clue to what is troubling the child. In this fashion some outline for future therapy may be made.

It is also important for the therapist to know how the child will react to the managing adult, how he will react to the group in general, to individuals in particular, to know what influences he seems to accept or reject, and how he reacts to just and unjust punishment. This can be carried out by initiating scenes in which a certain form of punishment is evoked, to see how the child reacts to the punishment and to the parent giving the punishment. Scenes are devised which will give some clue as to how a child reacts to reward, appeals, withdrawal of love, challenge, and to self-discipline.

Other situations have been devised to see what technique the child has made up to handle responsibility and how he alibies to himself and to others. Certain scenes will show how a child manages the demands of a group, and individual members of the group; others will show the effect of gang psychology in his thinking and acting. The person who is planning a psychodramatic course wants to know the child's ability to handle feelings of aggression toward father and mother, the reactions he has towards adults in general, his management of sibling rivalry (seen in so many children who have problems) and wants to know in general how these children act in any normal situation.

This last knowledge is used as a control in studying his abnormal behavior and thinking, which can only be known by devising situations through which the child may act spontaneously what he feels at the moment. This can be done by putting him into reality situations covering these points. In these scenes which the children are playing out, the other children constitute part of the scene or are present in the audience. By the therapist's handling of the unconscious basic fears that each child has as they are encountered in psychodramatic activity, the child is given much more security against the time when he next encounters this same fear.

The spirit of competition in the group helps to stimulate the play, and can be used as a very valuable asset in treatment. This may be done by putting the shy child first into a younger group, which permits him to be the most aggressive person in the group, and then, as improvement is shown,

by putting him into a group of his own age, where there is a more "give and take" relationship. If we feel that a child's problems center around one person, e.g., parent or teacher, the child is kept in the dramatic situation with the therapist alone, thus allowing the child to identify the therapist with the individual toward whom he has feelings of aggression.

By way of illustration, the case of Barbara, a fourteen year old girl, is cited. This youngster was brought to the Clinic because of the difficult home situation which she was creating through her inability to accept any form of discipline. This trait also manifested itself in her school activities. Her need to dominate any situation in which she found herself ultimately led to her being completely friendless. In this case the technique of "reversed roles" was employed. The child was persuaded to play the roles of mother and teacher, and in this fashion was given some insight into the problem she herself presented, because she could thus see herself in a more objective fashion. In this particular case the technique employed was successful. She had sufficient insight and intelligence to apply what she had learned from the play situation to her own life situation. Through the medium of psychodrama she was reassured about the anxieties which she displayed, and upon discharge from the Clinic, her aggression had disappeared to the extent that she had become socially adaptable and was assimilated into the conventional patterns of her own age group. In this case the mother was also under treatment, and quite soon a reasonable solution to their problems was achieved, whereas under ordinary methods, much more time would have been consumed in the establishment of rapport, exploration, and the working out of some reasonable solution to the problem.

The psychodramatic technique possesses an initial advantage over other therapeutic approaches with children in that children naturally tend to dramatize their life situations. Another advantage is that through this medium the child finds himself on a level of equality with the adult worker, who, prior to this time, would have constituted in the child's eyes principally a disciplinary force. In the case of children who have not had good relationships in the past with adults, this new relationship with an emotionally stable person helps them resolve their inner fears and conflicts. Another valuable tool in the psychodramatist's hands is an ability in the play situation to evoke from the child a lability which will carry over into everyday activities. One thing which should be constantly borne in mind is the recognition of a child's own interpretation of his play activity, because in

this fashion we may learn what method he has chosen for handling his conflicts and aggressions.

In studying and working with a large number of children by means of psychodrama, it was found that they all gave evidence of certain fairly typical reaction patterns. Each child goes through an initial period of resistance, which is nothing more than an expression of the aggression he feels toward the dramatist as an adult. This may be handled in various ways, depending on the type of youngster with whom one is dealing. The initial resistance is generally followed by a period which is characterized by the encouragement of spontaneity by the therapist. This is done by permitting the child to elect his own topics of conversation, to express his own interests, and to choose his own play and companions. The dramatist tries to keep the child at this time on a neutral level where his problems are not brought into the foreground. This is followed by a period of suggestion, where standard situations are set up for the child. An effort is made then to determine the child's difficulties. The standard situations are built around such things as wish-fulfillment (which may be acted out through the medium of fairy-tales), the playing out of future ambitions, and a gradual evolution of plots which show definite interpersonal relations. The fourth stage is known as the planned-therapy stage, where the actual work is done upon the problems, namely, encouragement of aggressive acts, and utilization of material which was found during the exploration or suggestion period. From this time on the child brings out more and more material bearing on his unconscious problems. This material is utilized in the way which will be most beneficial to the individual patient.

No child is treated unless the parents are being carried on a psychotherapeutic basis by another psychiatrist, because the parents must develop insight into the basis of the child's problems, and be able to carry on treatment at home, once the child is discharged from the Clinic. It would be very unwise, for instance, to let a child have an hour of aggressive, uninhibited play each week, if he must return home to face the same situation which precipitated his problems.

We have found in our work with the Child Guidance Clinic, that children fall roughly into one of three main groups. The type most frequently seen is the over-inhibited child, who reacts to his internal conflicts by means of terror dreams, anxiety attacks, or in some cases, develops physical symptoms manifested by feeding problems, nail-biting, and other neuropathic traits, sleep difficulty, and perhaps tics. Very frequently this kind

of child is shy, seclusive, and in general seems to demonstrate an undue amount of introversion. In many instances the parents are also found to indicate certain typical behavior. The mother is usually over-protective and over-restrictive, probably because she is compensating for some parental rejection in her own life. The father may be intolerant, and a perfectionist. Both parents together may show a lack of consistency in handling the behavior problems of the children. As a consequence the child is forced, through his own fear of parental rejection and loss of love to be "good", handling the aggressive feelings which he has by retirement into neurotic behavior.

Typical of the above-described group is the case of Phillip, a six-year old boy, who was brought to the Child Guidance Clinic because of the sudden appearance of facial muscular tics. In addition he had a long-standing problem of inability to socialize with children his own age. Phillip's mother was a typically over-anxious parent, who was always shielding her son from any possible danger, openly commenting on his neuropathic traits, and discussing his tics in front of him. Because of her over-protection she did not permit him freedom in mingling with children of his own age in natural play activity.

This case was handled by having the psychiatrist work with the mother upon her own problems of insecurity, with strong suggestions that she leave her son to his own devices, even though potentially these might involve some physical risk. The child was placed first in a group younger than himself, where he was permitted to be the leader. Next he was placed alone with the psychodramatist, where he was encouraged to work out his anxieties and aggressions with her as the identifying factor. Through gradual steps he was allowed to enter a group which was older, where, through competitive activities with other children, he became a normally socialized individual.

Another type of child frequently encountered is the aggressive, anti-social individual, who is referred to the Clinic mainly by the Court, school authorities, or juvenile delinquency agencies for evaluation. In general no effort is made to treat this kind of child because nothing is gained by further encouragement of his aggressive behavior through psychodrama, and he can only do harm to the group in which he is placed. This child's parents are usually not interested sufficiently in the child to come to the Clinic, and are not available for concurrent treatment. By way of aiding the child to respect discipline and the rights of others he is placed in a school or insti-

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tution which deals with problem children, and where these basic principles are enforced. Upon discharge from such an institution, he may be carried by the Clinic on a supportive basis.

To illustrate, we cite the case of Randy, an eleven year old, who was referred by the Juvenile Court because he was suspected of being the leader of a gang detrimental to his community. Because of this boy's innate intelligence and ability to get out of situations which might involve him unduly, he was sent to us for exploration. He was immediately enthusiastic about the Clinic, came voluntarily, liked the people he met, and within a few weeks asked if he might bring his whole gang. In seeing Randy in relation to the gang, it became evident that certain situations could be planned which would give indication of whether he was actually the group leader. One situation was set up in which a bicycle was to be stolen from a store window. Another time the boys were permitted to outline plans for blowing up a factory. Another instance involved the infringement of a school rule and expression of the means for avoidance of blame. In about eight out of ten such situations it was readily evident that Randy was the most resourceful, the initiator and planner of all the activities, that the gang was merely followers and Randy the leader. We were consequently able to give sound recommendations to the authorities on how this particular problem could be handled.

The third type of child may be characterized as "pseudo-social" in that he has conflicts with his group and with society in general, resolved by the committing of asocial acts, which have not yet reached the point where he would come in conflict with juvenile authorities.

An example of this kind of behavior is the case of Frances, an eleven year old girl, who was referred to the Clinic by a group of concerned neighbors and teachers. She had been seen on several occasions in acts of sexual perversion involving an animal. Frances was the second of a family of three children. There was a definite history of long-standing parental incompatibility. This child had been rejected, not only by her parents, but also by her own social group as a consequence of bringing into play the unhealthy attitudes of her parents, manifested by swearing and bickering. Another contributing factor was a parental verbal promise of a dog to the child as a reward for her good behavior. This promise was never kept, and the child was subjected to a constant resulting disappointment. All these factors together produced a very frustrating search for security and love, which her parents and group did not afford her.

The child was carried by the Clinic for a period of ten weeks. When
.he entered the Clinic she presented the picture of a very shy, withdrawn
ld unable to make contacts with either children or adults in the Clinic.
~as discovered that she had been a thumb-sucker since birth, although
fact was not reported by the parents. It is interesting to note that she
'to the Clinic very faithfully, and would remain, even though she did
articipate in any activity. The following will show the mechanisms of
sychodramatic approach in this case.
tor an initial period of three weeks the patient showed a very definite
nce to the group and to the dramatist, which was handled by leaving
d,ne, not forcing her into any group situation, but by making play
this and books available to her. During this time she constantly made
als out of clay material and her book interests were along the lines
Dr. Doolittle's animal stories. After the period of resistance wore off,
she began to affiliate with a group which was younger than herself. In this
group she was domineering and was able to carry it off, due to the fact
'hat she was an older child. Thus she acquired a rather precarious
security, which even so represented an improvement over her previous con-
ition. Subsequently she gained a good rapport with the dramatist. During
this time she gave some description of her preoccupation with animals and
frequently made indirect and somewhat derogatory references to her parents.

At the sixth week of treatment she was gradually put into standard
group situations, where she would be the most prominent member of the
group. Here she gave evidence of definite sibling rivalry, specifically,
jealousy of her sister, and a hostility toward her younger brother, which
took the form of actual planning of accident situations in which he would
be killed. Here she also showed the lack of consistency of treatment which
her parents had displayed toward her, and in her psychodramatic acting
she would play one parent against the other, in efforts to gain affection and
reward. She simultaneously demanded affection from the psychodramatist,
and made up situations in which she expressed her fantasies of the drama-
tist as an ideal parent. In cases where her wishes were fulfilled the thumb-
sucking stopped altogether.

During the eighth week of therapy, an interest in sexuality other than
expressions of sexual preoccupation with animals was more openly demon-
strated. It was discovered that her menstrual periods were about to be
established. She had had some cramps and one instance of spotting, which,
since she had been told nothing about the function, had given her much
anxiety.

Having determined the causative factors of this child's problems by means of psychodrama, it was decided that this approach had served its purpose, and from that point on, the therapy consisted of social hygiene talks, advice as to her personal relations to her group, and concommittantly, strong suggestions to her parents that they show more affection toward her, and that they give her the animal which they had promised her.

Following her discharge from the Clinic, return visits showed a very marked change in the child. She had given up her thumb-sucking entirely. She had become a member of the Girl Scouts, in which group she seemed to be well adjusted, and demonstrated more affection toward her family as a whole. Her parents had given her the dog, and this seemed to round out her happiness.

In summary, the perverted sexuality in this girl's case seemed merely a symptomatic manifestation of her inner conflicts, centering around her need for affection, her awakening sexual curiosity, and her misguided ideas of methods by which she could effectively dominate her group, in which she had a most insecure position. It was definitely felt here that although the girl's problems could have been ultimately resolved by any competent therapist over a long period of time, the psychodramatic techniques afforded a comparatively rapid method of solution of her conflicts. In any such case of therapeutic contact, a certain amount of transference is inevitable. Through the psychodramatic method, however, we were able to give the girl back to her group without a resulting feeling of loss and deprivation on her part.

<p style="text-align:center">*   *   *</p>

In this paper we have attempted to show how psychodramatics may be employed in the study of interpersonal relationships and as a therapeutic device. Work along these lines has been carried out, mainly in the Child Guidance Clinic affiliated with Duke University Hospital.

It was found that the children who are referred to the Child Guidance Clinic fall generally into three main groups: (1) the over-inhibited child; (2) the aggressive, anti-social child; and (3) the "pseudo-social" child.

The children under observation manifest certain fairly typical reaction patterns. There is an initial period of resistance, followed by a so-called spontaneity period in which a relationship is established with the therapist. Next comes a time when standard situations are set up for the child, and an effort made to determine his difficulties. The final stage is the planned-therapy period, when the actual work progresses upon the problem, both in relation to the child and to his parents.

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During the course of this work, certain broad principles seemed evident: (1) that dramatic activity is merely the outward manifestation of the child's innermost thoughts and fantasies; (2) that by the therapist's handling of the unconscious basic fears present in each child as they are encountered in psychodramatic activity, the child is given much more security against the time when he next encounters this same fear; (3) that through the situation in which the child finds himself with the dramatist, he is allowed to identify the therapist with the individual toward whom he has feelings of aggression and thus resolve these feelings.

Almost without exception the children treated become more socially adaptable and a reasonable solution to their problems was reached in a far less time-consuming way than would have been possible with other therapeutic methods.

GROUP PSYCHOTHERAPY

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The participants in this symposium have presented several methods which they have used to exert psychotherapeutic effect simultaneously on a large number of mentally ill and maladjusted persons. The inclusion of a paper on the prevention of mental illness through a visual educational effort is a healthy sign. The great interest in group therapy is indicated by the fact that this symposium was scheduled to be held in a room which would hold seventy people; its transfer to the largest room available was made necessary by the great number of persons wishing to attend.

· An historical review of the utilization of group psychotherapy would undoubtedly lead us to antiquity where all leaders of thought endeavored to influence men to a better way of life. As psychiatry has advanced the therapy of the neuroses has reached a point where large numbers of those disabled by neurotic illness may be cured. Individual therapy is so expensive and so time-consuming that it is often beyond the means of many people, and seldom is adequate individual therapy available in free dispensaries. Just as if insulin were still selling for the prices that were paid in 1924 many diabetic patients would be unable to afford treatment, so the group method of psychotherapy can make adequate treatment available to larger numbers and consequently bring efficient psychotherapy to persons unable to afford treatment under present systems. Although availability for greater numbers is important, I believe that we should not place emphasis upon this factor but rather upon the intrinsic value of group treatment and the points of superiority of the method over treatment on an individual basis.

Normal man does not exist in isolation but functions as a part of a community. His actions influence the group and his failure to contribute or to function adequately is a group affliction as well as an individual shortcoming. The aim in treating the maladjusted individual is to restore his ability to live with and to contribute to the group. In the traditional individual therapeutic relationship the patient relies upon the resources and influence of himself and the therapist alone to improve his adjustment; in the therapy group the patient soon sees himself as an individual in relationship to society, with the therapist occupying the symbolic position of the

wise and just parent and the group as an understanding and encouraging society. The individual neurotic, as a rule, regards himself as an unusual, different and miserable person, incapable of living a happy existence in society. The very feeling of isolation may account for his greatest anxieties. Everyone who has used the group method soon realizes that one of its most valuable assets is that it soon helps the patient to lose the feeling of isolation.

In our use of the group method we have utilized a technic which might be termed an informative, analytical, reactive method. At each weekly session we present briefly in simple language some fundamental psychodynamic principle, illustrating it by common examples. This initiates active discussion among the group, at which time the therapist draws from the members acknowledgment of recognition of the workings of these various principles in their own cases. At many sessions the case of a member of the group or a typical history is presented very briefly for discussion; by this method the patient vicariously identifies himself with the particular case under discussion, and it has been a frequent experience to have a half dozen or more in attendance express appreciation after the session for discussing their particular case. In this manner the shy individual may experience some vicarious catharsis.

We ask all patients admitted to the group—but do not make it compulsory—to supply us with a written history which includes a description of their symptoms, their childhood and general background, with a request that they supplement this as they acquire additional insight. Many patients refuse to comply with this request at first but usually do so after they have attended several sessions. At all times during the group discussions the therapist directs the answering of most questions to the group. Frequently we ask each person present to answer the question—even the one who presented it. In this way each patient is given the opportunity of reacting to the situation under discussion. Many times, when given the opportunity to do so, patients will discuss their own situations freely and identify themselves with others in the group; on these occasions every encouragement is lent to a deeper discussion by those with similar problems and views, as well as by those who hold opposite views. These discussion periods are simply guided by the therapist to unearth material deemed to be helpful to those present. It is in these periods of free discussion that patients have an opportunity by comment of activating some of their feelings of hostility and of ventilating repressed thoughts and desires. This obviously occurs even when

patients only listen, for they react emotionally to situations under discussion, and often patients who remain silent show evidence of intense emotional reaction and apparently obtain aid in acquiring insight by having problems which are bothering them discussed so freely. At times these sessions are dramatic and the reaction of the patients is therapeutically useful. We encourage all patients to verbalize their feelings and to participate in discussions but it is obvious that even without doing so they are influenced in their passive roles. We have had the experience of having patients acquire insight rather abruptly in the group, without disturbing effect. This has been particularly true in a group made up of parents of problem children. Many have acquired appreciation of the effect which their attitude and behavior have had upon their children—without becoming offended at the therapist and discontinuing therapy. In dealing with the neurotic parents of problem children we have found the group method most useful and I feel that one of the future applications of this method will be in parent education and in the field of child guidance. The presence of other parents with similar problems seeking understanding enables the parent to accept his faults and to acquire an objective attitude much more readily.

In group sessions all of the principles employed in individual therapy seem to have added emphasis lent them by the group spirit. There is undoubtedly a strong transference active in the group toward the therapist but this transference is spread to the group as a whole and possibly to individual members of the group. I have experienced very few occasions of annoying transference from members of the group. Despite the fact that we request all questions be asked before the group some infantile members seek individual attention after the sessions. We then request that such questions be asked before the next meeting. When this is done the group is requested to give the answer and the infantile person has to join in the discussion, and usually benefits far more than had it been aswered by the therapist. No one has persisted in asking inappropriate questions because of the mildly censorial comment and hostility which silly questions evoke from other members of the group.

In all of our groups we have accepted new patients at each weekly session. By doing so we have been afforded the opportunity of repeating certain fundamentals frequently. Our cases have not been selected and divided according to symptomatology but all have been grouped together, our only restrictions being that patients referred to the group shall under-

stand English well, that they shall possess no objectionable traits such as tics which might be disturbing to the group, and they must be emotionally reactive. At each session a brief presentation of the purpose of the group is made with emphasis upon the necessity of persisting in the efforts to acquire understanding through education. We have encouraged our patients to discuss material presented at the sessions as freely as they wish outside of the group, but have encouraged them to bring before the group individual problems and questions. All of our groups have been mixed except for one recently formed to deal with men separated from the services for psychoneuroses. Here the wives and even sweethearts of the members are encouraged to attend and seldom have we had a session at which several women were not present. Despite the mixed group discussions of sex problems have been free and without obvious restraint and apparently with benefit.

Following several weeks of attendance it is usual for individuals in the group to begin to report improvement in their outlook and disappearance of visceral symptoms. At each of our sessions we ask patients to state briefly on slips of paper any change in their condition since the last session or to ask any question they would like to have discussed. This gives us the opportunity of using the reports as a basis for potent suggestion, and the questions supply information about the needs of individual members.

After patients have attended eight or ten sessions they have usually heard discussed the role of emotion in the production of disturbance of bodily function. They have become acquainted with some of the workings of the unconscious mind; repression, sublimation, projection, ambivalence and similar mechanisms begin to take on meaning. The importance of infantile and early child life on the personality formation can be fully accepted, and with an objective attitude they can discuss the shortcomings and traumatizing activities of their parents. Sibling rivalry is regarded objectively and they begin to speak of their ambivalence with meaning. We believe that patients acquire intellectual and emotional insight more rapidly in the group than in individual sessions. They accept their unconscious motivations more readily and adjust more satisfactorily. Families can be helped to understand their structure more easily without activation of resentment. The sessions afford an impersonal but effective method of aiding in the solution of emotional problems involving a family or other group.

Our experience with psychoneurotics discharged from the military services is worthy of mention. Despite the fact they were found inadequate in

military setting these men have learned to act in groups, and from their service they have acquired some feeling of security. As may be expected, they fit into the group reasonably well. During their military life they had a consciousness of their importance; on return to civilian life many are depressed because of the unimportance of the role they play in the community. The group helps in the transition. Despite their ready acceptance of the group they do not respond as quickly as civilian neurotics because recovery may mean the loss of their meagre pension. The feeling of guilt which they have experienced as a result of their separation from the service is an almost constant characteristic of these veterans but this feeling disappears in the group. Once such patients have improved to the point of re-employment their progress is accelerated and seems to be retarded only by the regular re-examination at the Veterans' Bureau, which they usually regard as a threat to the security which their pensions afford. I believe that with sound psychiatric direction within the Veterans' Bureau and an appreciation by the veterans' own organizations that they will serve the individual veteran better when they place the emphasis on aiding him to a complete medical recovery rather than on increasing his compensation benefits the rehabilitation of these men will be made easier. Health, not "hand outs," is the thing to which our veterans are entitled.

By further use of the group we feel that a greater number of neurotics can be restored to effective living, not only because greater numbers can be reached but because many resistant to individual therapy will respond to group methods. The choice of method rests with the individual, but when we use the group we are using potent medicine whose properties must be understood. Marsh has appropriately pointed out that the neurotic is broken by the group and can be healed by the group.

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VISUAL AIDS IN GROUP PSYCHOTHERAPY: PUPPETRY[1]

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My work with group·psychotherapy in the Army has dealt largely with preventive psychiatry, and only more recently with the retraining phase. At Aberdeen Proving Ground, Maryland, I have spoken to many thousands of trainees in groups varying from 50 to 1000. Talks to them were always of the repressive-inspirational type as differentiated from the analytical. Very quickly it was found experimentally that group talks on preventive psychiatry improved morale, cut down maladjustments, and increased efficiency of training in new trainees. But also it very quickly became apparent that a means would have to be devised to make this intangible subject matter concrete and meaningful—this in addition to simple, non-technical language. The answer, of course, was the visual aid, which to me soon came to be synonymous with the best and only successful method of presentation in group psychotherapy.

Visual aids are effective because they are dynamic and help focus the listener's attention on the subject. They cause facts to be remembered 55% longer. They provide a background where none exists. But, it must be remembered, the aid must be simple. If necessary to get a point across, then exact anatomical and psychiatric principles may have to be altered. Physiological facts frequently may have to be interpreted freely. In general, "poetic license" may have to be taken in order to get a simple, interesting picture that will serve as a concrete background experience for listeners who have the varied background, mentalities, and educational achievements found in a lay group such as is represented by a cross-section soldier audience. Thus, to illustrate a talk to new trainees on homesickness and regimentation, simple charts without regard for anatomy were presented to show a "brain" consisting of emotions, a "body control section," and a "think box." To illustrate a talk on fear, use was made of symbolic figures. Emotions were represented by primitive animals under control; body control was represented by an overalled mechanic at a switchboard; and reason was represented by a familiar chap in the driver's seat.

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Furthermore, in order to reinforce the effect of the message from psychiatry, use was made of a picture-story form of booklet. The points we wished to put over from the talks were put into a cartoon booklet, A *Story of Mack and Mike*, depicting the life of two average new trainees. They are shown going through adjustment to Army life; the right and the wrong ways to meet military training are brought out.

The previously described group psychotherapy visual aids, however, all dealt with static presentation. Perhaps the best type of visual aid, therefore, is puppetry which was employed recently in retraining psychoneurotics, both of the domestic and battle variety. This method has all the concreteness of the other aids, but, in addition, has the added advantages of humor and movement. Puppets are admirably suited to presenting a basic understanding of human emotions to the average soldier, because a puppet as a symbolic character can easily project an abstract idea which a human actor would find difficult and involved. In effect, the puppet is a three-dimensional presentation of an otherwise completely abstract concept. In using puppets with Army men in an understanding of psychoneurosis, puppets make real such emotions as resentment, fear, anger, and sorrow; that is, they present convincingly the fact that these abstractions really exist. Thus, when a soldier has a painful foot he knows it is due to a blister because he can see the blister. In a like manner, when he is told that his bodily reverberations are due to emotion, he can now believe the relationship because he can see concretely that emotion at work. Furthermore, puppets are valuable because they can change their attitudes quickly. These small characters can change over from extreme euphoria and happiness to marked depression and sadness in considerably less time than it would take a human actor to make the transition. Therefore, the puppet can say things more convincingly within the limits of a short play; and what's more, can say things which no person could say and get away with.

In presenting the story of battle fatigue to soldiers, the relationship between emotions and exhaustion and physical symptoms is shown by depicting a soldier puppet, GI Joe, in a combat situation. For many days he has been pinned down in his foxhole, exhausted from lack of rest and sleep, constant shelling, canned food, threat of body injury and death. When his breaking point is passed from sheer exhaustion, normal control over emotions breaks down; and when to Common Sense, a capped and robed pro-

fessorial puppet, he replies, "I'm tired out and don't give a damn!", then
his emotions rapidly begin to gang up on him.

Rufus Resentment, a primitive loin-girded puppet, moves in on him
first. Explaining that "when the soldier is so tired he can't hang on and keep
control of his body," Rufus Resentment swings a club and bangs GI Joe
over the head with it. "I'll make his body hurt and shake so he won't even
recognize it!" Immediately, GI Joe reacts with resentment: "What a hole!
Why did I have to get stuck here? Where the hell is the rest of the Army?"
When next Freddie Fear, a tremulous terrified puppet, whimpers, "Did you
know that 20 panzer divisions were coming this way? Say, you ought to be
scared!", panic is registered. Then Archibald Anger, a red-faced scowling
puppet next slams GI Joe's head and roars, "I don't see why you stand for
all this stuff. Let them know you're no dope. Get so mad you don't know
what you're doing!" Sam Sorrow, a sad mournful puppet, finishes the job
with "Say, boy, it's a tough life you have here. It's a shame you had to
give up your civilian life for all this. Constant bombings, canned food, and
no sleep; it's enough to get any man down. Why don't you consider your-
self for awhile? Get feeling sorry for yourself." And as the scene ends, the
effects of the emotional onslaught are summarized by Rufus Resentment,
the ringleader, in "now we're the rulers of this man, Resentment, Fear,
Anger, and Sorrow. We can twist and turn his mind. We've got him so
mixed up, he won't be himself—not up here anyway. He's too tired to know
that his loss of appetite, belly pains, shakiness, heart pains, and blackout
are caused by us. He thinks he's sick from disease. He'll blame everybody
but us pretty soon. If we can just keep him from getting back his con-
trol; if he just won't have anything to do with that guy, Common Sense,
we'll keep him jumping through hoops!"

The concluding site is placed in an automotive shop. GI Joe, after the
rest and food of a hospitalization, has been returned to duty for retraining.
Now he listens intently as Common Sense tells him how to overcome his
psychosomatic complaints with "guts," a sense of humor, and interest in a
job. That the method works is amply shown, for the fortified GI Joe can
now withstand and control his troublesome emotions. In turn, he takes care
of Anger, Sorrow, and Resentment. To Archibald Anger's, "What are you
knocking yourself out for? You've got plenty to gripe about. Let the other
fellows do the job," he replies as he knocks Archie off the stage, "This war
isn't over with yet, see! I've got a job to do and if those guys think they

can give me trouble, they're way off the beam. This stuff I'm learning will not only help get this war over with, but will probably be of use to me in civilian life." To Sam Sorrow's "Civilian life's where you ought to be right now. Plenty of girls back home, you know," he replies with, "Quit now with all my buddies still fighting? What do you think I am?" as he throttles Sam off the stage. Finally, to Rufus Resentment's "Say, me pals tell me you don't listen to a thing they say. I thought you were on our side," he bats Rufus off the stage and closes with, "I'm on a side, you bet. On the side all my buddies are on—for victory and a free life. I'm on the side of getting this truck repaired so fast, it will knock out every last Fascist on earth. Buddies, there are millions on our side!"

SCIENTIFIC FOUNDATIONS OF GROUP PSYCHOTHERAPY

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The late arrival of group psychiatry and group psychotherapy has a plausible explanation when we consider the development of modern psychiatry out of somatic medicine. The premise of scientific medicine has been since its origin that the *locus of physical ailment is an individual organism*. Therefore treatment is applied to the locus of the ailment as designated by diagnosis. The physical disease with which an individual *A* is afflicted does not require the collateral treatment of *A*'s wife, his children and friends. If *A* suffers from an appendicitis and an appendectomy is indicated, the appendix only of *A* is removed, no one thinks of the removal of the appendix of *A*'s wife and children too. When in budding psychiatry scientific methods began to be used, axioms gained from physical diagnosis and treatment were *automatically* applied to mental disorders as well. Extra-individual influence as animal magnetism and hypnotism was pushed aside as mythical superstition and folklore. In psychoanalysis—at the beginning of this century the most advanced development of psychological psychiatry—the idea of a specific individual organism as the locus of psychic ailment attained its most triumphant confirmation. The "group" was implicitly considered by Freud as an epi-phenomenon of the individual psyche. The implication was that if one hundred individuals of both sexes were psychoanalyzed, each by a different analyst with satisfactory results, and were to be put together into a group, a smooth social organization would result; the sexual, social, economic, political and cultural relations evolving would offer no unsurmountable obstacle to them. The premise prevailed that there is no locus of ailment beyond the individual, that there is, for instance, no group situation which requires special diagnosis and treatment. The alternative, however, is that one hundred cured psychoanalysands *might* produce a societal bedlam together.

Although, during the first quarter of our century, there was occasional disapproval of this exclusive, individualistic point of view, it was more silent than vocal, coming from anthropologists and sociologists particularly. But they had nothing to offer in contrast with the specific and tangible demonstrations of psychoanalysis, except large generalities like culture, class and

societal hierarchy. The decisive turn came with the development of sociom-
etric and psychodramatic methodology.*

The change in locus of therapy which the latter initiated means literally
a revolution in what was always considered appropriate medical practice.
Husband and wife, mother and child, are treated as a combine, often facing
one another and not separate (because separate from one another they may not
have any tangible mental ailment). But that facing one another deprives
them of that elusive thing which is commonly called "privacy." What remains
"private" between husband and wife, mother and daughter, is the abode
where some of the trouble between them may blossom, secrets, deceit, sus-
picion and delusion. Therefore the loss of personal privacy means loss
of face and that is why people, intimately bound up in a situation fear to
see one another in the light of face to face analysis. (They prefer individual
treatment.) It is obvious that once privacy is lifted (as a postulate of in-
dividual psyche) for one person involved in the situation, it is a matter of
degree for how many persons the curtain should go up. In a psychodramatic
session therefore, Mr. *A*, the husband, may permit that besides his wife,
his partner in the sickness, the other man (her lover) is present, later his
daughter and son, and some day perhaps, they would not object (in fact
they would invite it), that other husbands and wives who have a similar
problem, sit in the audience and look on as their predicaments are enacted
and learn from the latter how to treat or prevent their own. It is clear
that the Hippocratic oath will have to be reformulated to protect a group
of subjects involved in the same therapeutic situation. The stigma coming
from unpleasant ailment and treatment is far harder to control if a group
of persons are treated than if it were only one person.

But the change of locus of therapy has other unpleasant consequences.
It revolutionizes also *the agent of therapy*. The agent of therapy has usually
been a single person, a doctor, a healer. Faith in him, rapport (Mesmer),
transference (Freud) towards him, is usually considered as indispensable
to the patient-physician relation. But sociometric methods have radically
changed this situation. In a particular group a subject may be used as an
instrument to diagnose and as a therapeutic agent to treat the other subjects.
The doctor and healer as the final source of mental therapeusis has fallen.

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*Sociatry is applied sociometry. The group psychotherapies are subfields of sociatry,
as the latter comprises also the application of sociometric knowledge to groups "at a
distance", to inter-group relations and to mankind as a total unit.

Sociometric methods have demonstrated that therapeutic values (tele) are scattered throughout the membership of the group, one patient can treat the other. The role of the healer has changed from the owner and actor of therapy to its assigner and trustee.

But as long as the agent of psychotherapy was a particular, special individual, a doctor or a priest, besides being considered the source or the catalyzer of healing power—because of his personal magnetism, his skill as a hypnotist or as a psychoanalyst—the consequence was that he himself was also the *medium* of therapy, the stimulus from which all psychotherapeutic effect emanated, or at least, by which they were stimulated. It was always his actions, the elegance of his logic, the brilliancy of his lecture, the depth of his emotions, the power of his hypnosis, the lucidity of his analytic interpretation, in other words, he, the psychiatrist was always the medium to which the subject responded and who in the last analysis, determined the mental status which the patient had attained. It was, therefore, quite a revolutionary change, after disrobing the therapist of his uniqueness, showing for instance that in a group of 100 individuals every individual participant *can* be made a therapeutic agent of one or the other in the group and even to the therapist himself, to go one step further and to disrobe all the group therapeutic agents themselves of being the media through which the therapeutic effects are attained. My means of a production on the stage a *third* element is introduced *besides* the healer and the patient-members of the group; it becomes the medium through which therapeutic measures are channelized. (This is the point where I went with psychodramatic methods beyond the methods I had used previously in group psychotherapy, even in its most systematic form—the group psychotherapies based on sociometric procedures and sociometric analysis.) In psychodramatic methods the medium is to a degree separated from the agent. The medium may be as simple and amorphous as a still or moving light, a single sound repeated, or more complex, a puppet or a doll, a still or a motion picture, a dance or music production, finally reaching out to the most elaborated forms of psychodrama by means of a staff consisting of a director and auxiliary egos, calling to their command all the arts and all the means of production. The staff of egos on the stage are usually not patients themselves, but only the medium through which the treatment is directed. The psychiatrist as well as the audience of patients are often left outside of the medium. When the locus of therapy changed from the individual

to the group, the group became the new subject (first step). When the group was broken up into its individual little therapists and they became the agents of therapy, the chief therapist became a part of the group (second step) and finally, the medium of therapy was separated from the healer as well as the group therapeutic agents (third step). Due to the transition from individual psychotherapy to group psychotherapy, group psychotherapy includes individual psychotherapy; due to the transition from group psychotherapy to psychodrama, psychodrama includes and envelops group psychotherapy as well as individual psychotherapy.

The three principles, subject, agent· and medium of therapy can be used as points of reference for constructing a table of polar categories of group psychotherapies. I have differentiated here eight pairs of categories: amorphous vs. structured, loco nascendi vs. secondary situations, causal vs. symptomatic, therapist vs. group centered, spontaneous vs. rehearsed, lectural vs. dramatic, conserved vs. creative, and face to face vs. from a distance. With these eight sets of pairs, a classification of every type of group psychotherapy can be made.

Table I

BASIC CATEGORIES OF GROUP PSYCHOTHERAPY

SUBJECT

Of Therapy

1. As to the *Constitution* of the Group

Amorphous	vs.	Structured (organized) Group
Without considering the organization of the group in the prescription of therapy.		Determining the dynamic organization of the group and prescribing therapy upon diagnosis.

2. As to *Locus* of Treatment

Treatment of Group in Loco Nascendi, In Situ	vs.	Treatment Deferred to Secondary Situations
Situational, for instance within the home itself, the workshop itself, etc.		Derivative, for instance in especially arranged situations, in clinics, etc.

3. As to *Aim* of Treatment

Causal	vs.	Symptomatic
Going back to the situations and individuals associated with the syndrome and including them *in vivo* in the treatment stiuation.		Treating each individual as a separate unit. Treatment may be deep, in the psychoanalytic sense, individually, but it may not be deep groupally.

Agent

Of Therapy

1. As to *Source* or *Transfer* of Influence

Therapist Centered vs.	Group Centered Methods
Either chief therapist alone or chief therapist aided by a few auxiliary therapists. Therapist treating every member of the group individually or together, but the patients themselves are not used systematically to help one another.	Every member of the group is a therapeutic agent to one or another member, one patient helping the other. The group is treated as an interactional whole.

2. As to *Form* of Influence

Spontaneous and Free vs.	Rehearsed and Prepared Form
Freedom of experience and expression. Therapist or speaker (from inside the group) is extemporaneous, the audience unrestrained.	Suppressed experience and expression. Therapist memorizes lecture or rehearses production. The audience is prepared and governed by fixed rules.

Medium

Of Therapy

1. As to *Mode* of Influence

Lecture or Verbal vs.	Dramatic or Action Methods
Lectures, interviews, discussion, reading, reciting.	Dance, music, drama, motion pictures.

2. As to *Type* of Medium

Conserved, Mechanical or Unspontaneous vs.	Creative Media
Motion pictures, rehearsed doll drama, rehearsed dance step, conserved music, rehearsed drama.	Therapeutic motion pictures as preparatory steps for an actual group session, extemporaneous doll drama with the aid of auxiliary egos behind each doll, psychomusic, psychodrama and sociodrama.

3. As to *Origin* of Medium

Face to Face vs.	From-a-Distance Presentations
Any drama, lecture, discussion, etc.	Radio and television.

VALIDITY OF GROUP METHODS

All group methods have in common the need for a frame of reference which would declare their findings and applications either valid or invalid. One of my first efforts was therefore, to construct instruments by means of which the structural constitution of groups could be determined. An instrument of this type was the sociometric test and it was so constructed that it could easily become a model and a guide for the development of similar instruments. My idea was also that if an instrument is good, its findings and discoveries would be corroborated by any other instrument which has the same aim, that is, to study the structure resulting from the interaction of individuals in groups. After social groups of all types had been studied, formal and informal groups, home groups and work groups, and so forth, the question of the validity of group structure was tested by using first deviations from chance as a reference base, second by control studies of grouping and regrouping of individuals.

Deviation from chance experiments. A population of 26 was taken as a convenient unit to use in comparison with a chance distribution of a group of 26 fictitious individuals, and three choices were made by each member. For our analysis any size of population, large or small, would have been satisfactory, but use of 26 persons happened to permit an unselected sampling of groups already tested. Without including the same group more than once, seven groups of 26 individuals were selected from among those which happened to have this size population. The test choices had been taken on the criterion of table-partners, and none of the choices could go outside the group, thus making comparison possible. Study of the findings of group configurations (resulting from the interacting individuals) in order to be compared with one another, were in need of some common reference base from which to measure the deviations. It appeared that the most logical ground for establishing such reference could be secured by ascertaining the characteristics of typical configurations produced by chance balloting for a similar size population with a like number of choices. It became possible to chart the respective sociograms (graphs of interactional relations) of each experiment, so that each fictitious person was seen in respect to all other fictitious persons in the same group; it was also possible to show the range in types of structures within each chance configuration of a group. The first questions to be answered read: What is the probable number of individuals who by mere chance selection would be picked out by

their fellows, not at all, once, twice, three times, and so on. How many pairs are likely to occur, a pair being two individuals who choose one another. How many unreciprocated choices can be expected on a mere chance basis? The experimental chance findings followed closely the theoretical chance probabilities. The average number of pairs in the chance experiment was 4.3, in the theoretical analysis 4.68 (under the same condition of 3 choices within a population of 26 persons). The number of unreciprocated choices was in the chance experiments 69.4, the theoretical results showed 68.64 under the same conditions.

Among the many important findings the most instructive to the group psychotherapists were: a) a comparison of the chance sociograms to the actual sociograms shows that the probability of mutual structures is 213 per cent greater in the actual configurations than in chance, and the number of unreciprocated structures is 35.8 per cent rarer actually than by chance; the more complex structures such as triangles, squares and other closed patterns of which there were seven in the actual sociograms were lacking in the chance sociograms; b) a greater concentration of many choices upon few individuals, and a weak concentration of few choices upon the majority of individuals, skewed the distribution of the sampling of actual individuals still further than took place in the chance experiments, and in a direction it need not necessarily take by chance. This feature of the distribution is called the *sociodynamic effect*. The actual frequency distribution compared with the chance distribution showed the quantity of isolates to be 250 per cent greater in the former. The quantity of overchosen individuals was 39 per cent greater while the volume of their choices was 73 per cent greater. Such statistical findings suggest that if the size of the population increases and the number of choice relations remain constant, the gap between the chance frequency distribution and the actual distribution would increase progressively. The sociodynamic effect has general validity. It is found in all social groupings whatever their kind, whether the criterion is search for mates, search for employment or in socio-cultural relations. The frequency distribution of choices shown by sociometric data is comparable to the frequency distribution of wealth in a capitalistic society. In this case also the extremes of distribution are accentuated. The exceedingly wealthy are few, the exceedingly poor are many. Economic and sociometric curves are both expressions of the same law, a law of sociodynamics.

Control studies. Two groups of individuals were compared. In the one, Group A, the placement to the cottage was made hit or miss, in the

second, Group B, the placements were made on the basis of the feelings
which the incoming individuals had for the cottage parent and for the other
inhabitants of the cottage, and *vice versa*. Sociometric tests were then ap-
plied at intervals of 8 weeks so that we could compare the structure of the
control group A with the tested group B. Among other things it was found
that the tested individuals undergo a quicker social evolution and integra-
tion into the group than the individuals who have been placed in a cottage
hit or miss. At the end of a thirty-two weeks period the control group
showed four times as many isolated individuals as the tested group. The
tested group B showed twice as many individuals forming pairs than the
control group.

Indications and contra-indications of group psychotherapy. The indi-
cation of group psychotherapy or of one particular method in preference to
another must be based on the sociodynamic changes of structure which can
be determined by means of group tests of which two illustrations have been
given above. Group psychotherapy has come of age and promises a vigor-
ous development largely because group theory and group diagnosis have
paved the way and have kept pace with the rapidly expanding needs for
application.

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LECTURE METHODS

THE GROUP METHOD IN THE TREATMENT OF PSYCHOSOMATIC DISORDERS

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In 1913, Dr. Smith Ely Jelliffe of New York translated and edited a book entitled "The Psychoneuroses and Their Treatment by Psychotherapy." It was the work of the distinguished French neurologist, J. Dejerine (1) and his pupil E. Gauckler. For some reason, this very important book was not widely read and reference has rarely been made to it by American or English writers on the psychoneuroses. An exception was the English psychiatrist, T. A. Ross, who in the preface of "The Common Neuroses" (2), published in 1923, stated that Dejerine is the writer to whom he owes most. He adds that Dejerine was not lucky in the time of publishing his psychological books as "English Psychotherapists were under the spell of Freud," whose conceptions were "so much more brilliant and fascinating than Dejerine's who lived in a plain work-a-day world, that this not need surprise anyone. "Now, however," Ross went on to say, "Freud's views are less potent therapeutically than it was at one time hoped they would be. The time has perhaps come when the more sober and less dazzling idea may receive some of the attention which it failed to attract ten years ago." This hope was only partially realized, as Ross's book like Dejerine's earlier work did not make the impression on the medical profession of this country that it deserved.

At the outset of his career, Dejerine used Weir Mitchell's methods which were based on purely physical measures but it was not long before he made the important discovery that "unless the patient's state of mind improved, the therapeutic results were far from satisfactory." He thus came to realize that in order to cure patients suffering from functional nervous disorders, "the first and most important thing was to get hold of their morale, in other words, to practise psychotherapy." This he had been doing for a quarter of a century before he wrote his book with a success that indicates the soundness of his views. He recognized that the cause of this success was the moral treatment he employed. Unless moral and spiritual re-education leads to effective action, there is no persuasion. To effect a cure a change must be wrought in the personality of the patient, and this is only brought about when the patient has acquired absolute confidence

in his physician. There must be an emotional appeal that makes the new ideas "acceptable to consciousness and this brings about conviction."

Dejerine was one of the first to realize that psychosomatic disorders are due to emotional maladjustments and that cure results by removing the emotional cause, and replacing bad emotional habits with good ones. As he treated the emotional cause and not the varied physical symptoms the patients presented, unlike most neurologists and psychiatrists in this country, he did not limit his practice to patients presenting nervous and psychic manifestations but included all cases of emotional origin that were brought to him. He recognized a truth known to Sydenham three hundred years ago but unknown, unfortunately, to most physicians today that pain localized in any part of the body may be due to hysteria or hypochondriasis, in other words to an emotional cause.

Knowing that the seat of the disorders was in the personality of the patient, Dejerine treated with success scores of cases with digestive disturbances, cardiovascular, respiratory, and genito-urinary symptoms as well as other conditions in which the somatic features seemed on superficial study to form the entire clinical picture. Painstaking inquiry, however, brought to light the underlying emotional disturbance which was the cause of the illness.

As Ross points out, Dejerine's treatment is a form of faith cure; faith in the psychotherapist or, as I hope to show later, faith in a group or class and its teachings. Dejerine realized this and in one place quotes the old adage "It is faith that saves . . . or cures."

It was about thirty years ago that Dejerine's book came into my hands. From it, I learned a method that I was able to employ with success in the treatment of the neuroses. Up to that time, I had relied chiefly on physical methods, such as rest, exercise, baths, and congenial work. After a thorough physical examination supplemented by laboratory tests, I would tell the patient that he had no organic disease. This reassurance, as Dejerine points out, was about the limit of the psychotherapy practised by most physicians and needless to say, it was rarely effective in removing the patient's symptoms.

I recall vividly the first patient that I treated by Dejerine's methods and the diligence with which I attempted by study of his book to carry out the treatment exactly as he advised.

The patient was brought to Boston from her home in North Carolina to consult me. She came reluctantly at the insistence of her husband who

accompanied her. She told me in the first interview, and I detected a note of pride in her voice, that she had consulted twenty-four physicians and none had given her the least help. I determined then that if possible, with Dejerne's help, that I would not be the twenty-fifth in an endless series. She had severe indigestion accompanied by occasional attacks of intense abdominal pain that alarmed nurses and physicians. Every doctor she consulted had prescribed a diet but none of these had lessened her distress. Her weight had dropped to less than one hundred pounds. Her complaints were all referred to her abdomen and her mental state had never been investigated. Several interviews of an hour each, as Dejerine advised, were employed in taking the history. I let her talk without interruption until she had told all she wished to tell. Then I drew out information regarding her emotional life although in her mind it had no bearing on her illness. At last I knew the events of her life in some detail and also her attitude of mind. Then I sought to trace a relationship between her attacks of intestinal colic and her emotional state at the time they occurred. The last seizure had taken place several months before I saw her and had been unusually severe. It was due she said to eating a cucumber salad. "Wasn't that at about the time of your mother's death?" I inquired. "Yes, a few days before the end," she replied. I learned that she was so prostrated by her mother's illness that she had to take to her bed and could not even visit her mother before she died. "Did you see no relation between your mental agitation and the attack of severe colic?" "No," she said, "I was sure it was the cucumber salad that caused it." I had little difficulty in persuading her to accept Dejerine's teachings. Soon she was eating everything without distress and gained weight rapidly.

Since then I have employed this common sense psychotherapy over the years and have demonstrated repeatedly that functional nervous disorders are the result of abnormal emotional reactions and are cured by treating the patient's personality.

Individual treatment is costly in time to the physician and costly in money to the patient. It cannot be employed in large out-patient clinics for two reasons. (1) The patients are too numerous. (2) Those who can employ psychotherapy successfully are too few.

In the large medical clinic of the Boston Dispensary, I taught my assistants to recognize the functional nervous cases. Correct diagnoses greatly increased the number of cases that were recognized to be functional nervous disorders. An analysis of 500 cases admitted to the Medical Clinic

revealed the fact that over thirty per cent belonged in this category. These came to the Clinic complaining of somatic symptoms. Those with frank nervous symptoms were not included as they were referred directly to the Nerve Clinic by the admitting office. Many of the cases which we found to be personality disorders had previously been regarded as examples of organic diseases. Hyperacidity, chronic rheumatism, neuritis and neuralgia, chronic appendicitis, back strain and sacro-iliac disease, and the menopausal syndrome were among the frequent false diagnoses which we had to correct. Although the right diagnosis was made, treatment by persuasion and moral education seemed impossible. The treatment we did employ with individual patients was as ineffective as in other clinics and as a result the patients often made visit after visit over months and years complaining of the same symptoms.

As I had employed the group or class method years before in the treatment of pulmonary tuberculosis (3), it occurred to me that this method might be useful in meeting the pressing problem presented by our emotionally maladjusted patients. At least I would have the opportunity of giving them some information in regard to the effects of emotional reactions on the body and some instruction in mental hygiene.

The first meeting of the group was on the morning of April 11, 1930. Since then meetings have been held once a week except during a summer recess. At the start I had the able assistance of Miss Edith Canterbury of the Social Service Department. At the outset, I had no idea how to proceed as I had no precedent. I felt like a mariner traveling uncharted waters. Three women patients from the Medical Clinic were present at that first meeting and the testimony of one of them of her recent relief from pain gave us a successful start. A few days earlier I had interviewed this patient, Mrs. C., in the Medical Clinic. I had already at that time gained her confidence as some months previously she had come to me complaining of pain in the shoulder and had speedily recovered. This time her condition was much more serious. For three months she had had a pain in the back so severe as to confine her to bed. Finally she had managed to make the trip to the office of a prominent gynecologist. He found some minor pelvic abnormality and to this attributed her disabling backache. He recommended an operation, and as she was a poor woman, had referred her to my clinic at the Boston Dispensary to determine whether her general condition would permit of his undertaking the operation without delay.

Although she complained only of the back ache, after listening to her

story, I said, "What is the real trouble? Tell me the whole story." Without hesitation she replied that it had been fear her husband would lose his job. This had tormented her for months. He looked so tired and wan at night on returning home from work that she was filled with forebodings. It was very difficult to pay the bills with his meagre wages, and what would happen to the children if he became sick and could not work? This state of mental agitation had persisted for some time when the back ache developed. Her relief of mind was very great when I assured her no operation was needed and that her back ache would disappear when she banished her fears and gained mental serenity. She accepted my statement at once without the least questioning doubt.

At the first class meeting, she instilled hope into the minds of the other two patients by telling the story of her dramatic recovery. When she had come to the Dispensary to ascertain whether her condition would warrant the operation, she was so weak that she had to steady herself by keeping her right hand on the brick walls of the buildings as she walked down narrow Bennet Street to the Dispensary. When she left she felt as if she were walking on air. She kept repeating to herself, "No operation, no operation." She stopped at the market on her way home and bought provisions. That afternoon she washed the kitchen floor and for the first time in three months prepared her husband's supper. The back ache was gone.

A few months later with health restored after faithfully following the instructions given at the class meetings, she told the following incident: A few days earlier a friend had stopped her on the street and drawing her to one side said in low tones, "Everyone is talking of your wonderful recovery, Mrs. C., but you tell me the truth for I know it was a miracle. You visited Father Powers' grave at Malden and were cured." "No," replied Mrs. C. "It wasn't Father Powers' grave, it was Dr. Pratt's thought control class." That gave us our name. We had been at a loss to find a suitable name, and here it was supplied by an uneducated member. She had grasped the central teaching that cure was wrought by thought and emotional control. A strong vitalizing emotion had removed her pain but the underlying cause of it had been eradicated by an altered state of mind; in other words by moral re-education as Dejermine termed it.

As I was the physician-in-chief of the Medical Clinic, I was able to make a ruling that all patients whose symptoms were found on thorough examination to be due to a functional nervous disorder were to be referred

to the class without delay. As a result over 2,000 patients have been sent to us. Two psychologists, Mr. Winfred Rhoades and Dr. Rose Hilferding are in daily attendance at the Dispensary and they hold a preliminary interview with all patients before they attend their first meeting. At this interview a psychological history is added to the medical record. A brief explanation is given of the effects of the emotions on the body and mind in an effort to break down the resistance many patients feel to psychological treatment.

The methods used in conducting the meeting have been little changed during the fifteen years of its existence. They were described in some detail in a previous paper (4). The members are seated in the lecture hall according to the number of sessions they have attended. The four with the highest score sit on a settee placed on the platform to the left of the class leader and facing the other members of the class. This was done at the suggestion of the late Dr. John G. Gehring, the distinguished psychiatrist who supported the class idea from its inception. He wanted the patients who had been members for some time and who had recovered to sit in such a position that the new comers could see what he termed the radiance in their faces. The newcomers, that is the candidates for membership, are seated on the front row facing the director. The roll call is made and the class director repeats the name and enters it in a book together with the number of meetings attended by each member beginning with the one with the largest number. This breaks the ice and it serves as an introduction of each member to the others of the group. They come in this way to associate the names and faces of their fellow members. The floor secretary then distributes slips of paper on which each records his progress or lack of progress since the previous meeting. These are collected at once and read by the class director without giving the names signed on the reports. With an average attendance of 20, about 15 will state that they are free from symptoms and feeling "fine". The other five composed chiefly of new members write that they are no better or only a little improved. Those in the latter group are asked to remain after the class in order that they may be given appointments for personal consultations with our psychologist or with our psychiatrist, Dr. Alfred Hauptmann. All patients who fail to gain after a few treatments are studied by Dr. Hauptmann and when found to be suffering from psychoses as occasionally happens are advised regarding other treatment more suitable for them.

Then a relaxation exercise is given. The form I employ is really mild

hypnotic suggestion combined with relaxation. For this technique I am indebted to Professor Elton Mayo. This entire procedure lasts only five to seven minutes. As a result, nearly all feel relaxed in muscles and mind, as is indicated by raising their hands. As their eyes are closed at the time, they do not know the result, but I always announce how many failed to relax and they are usually only the newcomers. A few may fall asleep and most of the group claim they feel drowsy. This exercise seems to prepare them well for the short address that follows. These talks aim to be inspirational. Dr. Giles W. Thomas (5) characterized our entire method of treatment as repressive-inspirational in contrast to the psychoanalytical and the intellectual methods. I made it a rule not to prepare in advance my little speech. There is much repetition but this is well received by my hearers as many attend the meetings for months or even years after their recovery. I appeal to their hearts rather than their heads; in other words, to their emotions more than to their reason. Dejerine emphasized the truth that action is due to an emotional drive and without action, there is no cure. "You can't change the world, so change yourself," is a favorite quotation that the members recite with conviction. Following the talk by the class director, the final ten or fifteen minutes of the hour and a half session are devoted to testimonies from two or three of the members who speak of the progress they have made and the lessons they have learned from their experience.

Patients in the class have usually recovered more quickly than have my private patients. This I attribute to hope of recovery awakened by being in the presence of those who were sick and now are well, and secondly to faith in the class and its methods as well as in the directing physician.

Other classes have been formed in our clinic and conducted with equal success. Winfred Rhoades, our psychologist has had an evening class for nearly ten years, established primarily for men who were employed during the day but is now attended by both men and women. He published an excellent account of the group method (6). His book "The Self You Have to Live With" (7) is made up in part of material used in the short addresses prepared for his class and contains also many experiences of class members who had learned to adjust themselves to the conditions of life. This book has proved so helpful that it has been reprinted twelve times. Dr. Herbert I. Harris (8) organized and conducted an afternoon class. His report on the group method is excellent. Dr. Alfred Hauptmann (9), a psychiatrist with large experience in leading German clinics, after a thorough study of

our results, published a paper in which he emphasized certain advantages of the group method over individual treatment. He pointed out that it should prove of special value in dealing with the war neuroses among the soldiers. For this reason, the paper was sent for publication to "War Medicine," but the editor returned it evidently regarding the subject of group treatment not sufficiently important to deserve publication. Yet within two years, General Marshall issued a general order that group therapy should be employed by the psychiatrists of the Army.

So far as I know the first class to be formed along lines similar to ours was that of Dr. Samuel B. Hadden (10) in the outpatient department of the Presbyterian Hospital of Philadelphia early in 1939. A later paper (1) reported the success he had obtained, as a statistical analysis of the results of the first three years of the group therapy showed that of those who responded to the questionnaire, 90 per cent reported they were benefited; 18 per cent as cured, and 50 per cent as much improved.

Anyone who has developed a successful psychotherapeutic method of treating individual patients can conduct a class with success but on the other hand if he has not achieved an effective technique with individual patients, I doubt if he will succeed with a group.

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THE COMBINED SYSTEM OF GROUP PSYCHOTHERAPY AND SELF-HELP AS PRACTICED BY RECOVERY, INC.

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Recovery, Inc. was founded in 1937 by thirty patients who recovered their mental health after receiving shock treatment at the Psychiatric Institute of the University of Illinois medical school. Originally concerned with after-care for former mental patients exclusively, it now admits to membership both psychoneurotic and postpsychotic persons. Its main objective is to reduce the incidence of relapses in mental disease and to combat chronicity in psychoneurotic conditions.

THE CASE OF THE FORMER MENTAL PATIENT

It was only after Recovery came into being that the author had an opportunity to acquaint himself with the fate of the discharged mental patient. In pre-Recovery years, his private patients were seldom seen after termination of hospital treatment, and his contact with patients discharged from public institutions was largely limited to the official three parole visits which added to an already voluminous case record but failed to enlarge the volume of the physician's knowledge about his patients. In the past eight years close contact was established with hundreds of discharged mental patients in private interviews, classes, committee conferences, instruction courses, social parties and home gatherings. The experience gained in these multiple contacts demonstrated that the majority of former patients are the victims of distressing sensations, fears and panics. These "residual symptoms" call for early after-care if the problem of relapse is to be attacked systematically.

The residual symptom gives rise to anxiety. The popular superstition of "once mentally ill, always mentally ill" is forcefully endorsed by the evidence that the patient is "slipping again." Fears and panics are now fanned into a hysteria that grips patient and family alike.

Recovery insists that the patient, prior to leaving the hospital, attends group psychotherapy classes in which he is given adequate instruction how to face the threat of the residual symptom and the pressure of stigmatization. At the same time, the members of the family are urged to attend

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discussion courses in which similar instruction is offered. In this manner, the pre-discharge care prepares for the after-care effort.

THE CASE OF THE PSYCHONEUROTIC PATIENT

Recovery deals with chronic, protracted cases of psychoneuroses mainly. Patients with symptoms of a few months' duration are rarities in the ranks of the group. Most members have a record of from two to twenty years of suffering. These "experienced sufferers" have made the round of physicians and clinics and were assured on numerous occasions that some therapeutic measure will cure them. The assurance never materialized with the result that they no longer believe a cure possible. They know, however, that some or most of the past therapies had a transient palliative effect. The palpitations were milder after a reassuring talk; the dizziness yielded to a sedative. Hence, they treasure the "pep-talk" or the prescription. Essentially, they have decided that all they can expect is temporary relief, not a final cure. The "chronicity" of this group is not based on etiological or clinical considerations; it is self-appointed defeatism.

THE "RECOVERY" APPROACH TO DEFEATISM

Recovery ignores etiology and classification. Conflicts and complexes, infantile traumas and subconscious ideologies play little or no part in the class interviews conducted by the physician and the self-help activities carried on by the patients. The patient is considered a person who for some reason has developed disturbing symptom-reactions leading to ill-controlled behavior. The symptoms are in the nature of threatening sensations, "intolerable" feelings, "uncontrollable" impulses and obsessive "unbearable" thoughts. The very vocabulary with its frenzied emphasis on the "killing" headache, the dizziness that "drives me frantic," the fatigue that is "beyond human endurance" is ominously expressive of defeatism. The first step in the psychotherapeutic management must be to convince the patient that the sensation can be endured, the impulse controlled, the obsession checked. Unfortunately, the physician is far from convincing. His attempt to "sell" the idea of mental health arouses the "sales resistance" of the patient. "The physician doesn't dare tell me the truth. It would be against his ethics to declare me incurable." The resistance is easily overcome in the group interview. The fellow sufferer who explains how he "licked" his frightful palpitations after years of invalidism cannot possibly be suspected of trying

to sell something. That "colleague" is convincing. He convinces the novice that chronic conditions are not hopeless.

THE PATIENTS MEET ON THREE DAYS EVERY WEEK

On three separate days each week the patients take part in group discussions, either as panel members or listeners. On Wednesdays, a family gathering is held in a private home. There a panel of three or four experienced members discuss a chapter of the author's three volumes on self-directed after-care.[1] The theme is centered on the topic of symptoms and the proper means of conquering them. Thursday evening is devoted to a group psychotherapy class, conducted by the author. Saturday afternoon, a public meeting takes place in the Recovery office located in a downtown building. It is attended by the patients, their relatives and friends. The first half hour is given over to a panel discussion similar to that held at the Wednesday home gatherings. In the second half the author delivers an address in which he sums up the conclusions reached by the panel, approving or correcting their statements. The panel members are led by the panel leader.

TREATING THE "SETBACK"

Patients are required to attend classes and meetings for at least six months. The charges for class attendance are $10.00 a month, the dues for Recovery membership are $2.00 a year. The average patient experiences a considerable improvement in the first or second week of participation in the program. But the improvement is, as a rule, as short-lived as was the relief which the patient used to gain from the visits to clinics and doctors' offices. No meetings are held between Saturday and Wednesday. In the intervening four days the novice is apt to suffer a "setback." He is again tortured by "that awful fatigue" or has been unable "to sleep a wink for three nights in succession," or the fear of doing harm to the baby reappears after it was gone for a short while. Every patient is warned to be on guard against the unavoidable setback. He is cautioned to contact a veteran Recovery member immediately after the symptom has reappeared. The assurance offered by the veteran is usually couched in the statement, "the doctor warned you that you are in for a setback. When I had mine I

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[1]A. A. Low, *The Techniques of Self-Help in Psychiatric After-Care*, 3 volumes, Chicago, 1943, published by Recovery, Inc.

knew that sensations are distressing but not dangerous. That helped me. I waited till the sensation disappeared." Each new member is assigned to a veteran whom he may call in distress. The veteran functions in the capacity of the physician's "aide." The contact is generally made by telephone but may be done by a personal visit to the aide's home. If the result is not satisfactory the novice is permitted to call on the leader of his local panel. If this is ineffective he may contact the chairman of the organization who serves as deputy to the physican. Finally he may call the physician.. The effectiveness of the scheme is evidenced by the fact that the author remembers few instances only in which he was called by novices.

The "Symptomatic Idiom"

Language, by dint of defeatist implications, engenders tenseness which reinforces and perpetuates symptoms. To avoid the fatalistic implications of the language used by the patient the physician must supply a terminology of his own in matters of health. There are many languages. Features and gestures speak. So do symptoms. Their language is a one-word idiom: danger. This is called the "symptomatic idiom." Accepting the implications of the symptomatic idiom the patient considers the violent palpitations as presaging sudden death. The pressure in the head is viewed as due to a brain tumor. The tenseness is so "terrific" that the patient fears he is going to "burst." His fatigue does not let up "one single minute," and "how long can the body stand that?" In these instances, the implications of the symptomatic idiom are those of an impending *physical collapse*. If phobias, compulsions and ruminations dominate the symptomatic scene the resulting fear is that of the *mental collapse*. After months and years of sustained suffering the twin fears of physical and mental collapse may recede, giving way to apprehensions about the impossibility of a final cure. This is the fear of the *permanent handicap*. The three basic fears of physical collapse, mental collapse and permanent handicap are variations of the danger theme suggested by the symptomatic idiom.

The "Temperamental Lingo"

Temper is linked to symptoms in a two-way relationship. The symptom arouses fear or anger, the latter when the patient "gets sore at himself" and "works himself up." After the temper is aroused it reinforces and intensifies the symptom which again increases the temperamental reaction. In this

manner, a vicious cycle is established between temper and symptom. After proper training the patient has no difficulty controlling panicky fears and angry outbursts. But panics and tantrums are merely the extremes of temper. In its middle range temper is subtle, elusive and deceitful. It deceives by means of the "temperamental lingo." By labelling sensations as "intolerable," feelings as "terrible," impulses as "uncontrollable" the lingo discourages the patient from facing, tolerating or controlling the reaction. All a patient has to do is to call a crying reaction by the name of "crying spell," and no effort will be made to check the burst of tears. The word "spell" suggests uncontrollability. Make the patient substitute "crying habit" for "crying spell," and the impossibility of stemming the flood is at least not taken for granted. Similarly, if the patient raves about the "splitting" headache, the dizziness that "drives me mad," the pressure that "I can't stand," the fatalism of diction is bound to breed a despondency of mood. In order to prevent the temperamental response the patient must be trained to ignore the whisperings of his temperamental lingo.

The "Recovery Language"

The combined effects of symptomatic idiom and temperamental lingo are checkmated if the patient is made to use the physician's language only. The members call it proudly the "Recovery language." Its vocabulary is limited in the main to two words: "sabotage" and "authority." The authority of the physician is sabotaged if the patient presumes to make a diagnostic, therapeutic or prognostic statement. The verbiage of the temperamental lingo ("uncontrollable," "unbearable," etc.) constitutes sabotage because of the assumption that the condition is of a serious nature (diagnosis) and difficult to repair (prognosis). It is a crass example of sabotage if the claim is advanced that "my headache is there the very minute I wake up. I didn't even have time to think about it. It came before I even had a chance to become emotional. How can that be nervous?" This throws a serious doubt on the validity of the physician's diagnosis and sabotages his authority. Likewise, it is a case of self-diagnosing and consequently sabotage to view palpitations as a sign of heart ailment and pressure as meaning brain tumor. Once the physician has made the diagnosis of a psychoneurosis or postpsychotic condition the patient is no longer permitted to indulge in the pastime of self-diagnosing. If he does he is classed as saboteur. Patients are required to lose their major symptoms after two

months of Recovery membership and class attendance. If after the two month period the handicap persists in its original intensity the indication is that sabotage is still in action. The patient still listens to the suggestions of the symptomatic idiom fearing impending collapse and permanent handicap. Or, he indulges in the verbal vagaries of the temperamental lingo, feeling helpless in the face of suffering. Clinging to his own mode of thinking he sabotages the physician's effort.

Contrary to expectation, it is comforting to the patient to be branded a saboteur. Considering himself as such he knows that he has "not yet" learned to avoid resisting the physician. The "not yet" is reassuring. It suggests that in time he will learn. "Wait till you get well;" "wait till you will learn to give up sabotaging;" these are most effective therapeutic slogans handed down from veteran to novice.

General Comment

The description here given of the Recovery system is sketchy and fragmentary at best. Even so it may be expected to convey a tolerably correct bird's eye view of its basic principles. Its main effect is to discipline the patient, to make him bear, or at least, share the responsibility for his continued invalidism. Essentially it tells the patient: The physician gives you the opportunity to conquer your handicap. If you engage in sabotage activities the process of getting well will be delayed, and the responsibility for prolonging your suffering will rest on you. The procedure may savor of dictatorial harshness but is nothing but firm leadership. That this is so can be easily gathered from the spirit of cordiality that is characteristic of the physician-patient relationship within the Recovery framework. This is not the place nor the time to offer results in terms of percentages of cures. Suffice it to state that the author has been able, with the aid of Recovery technique, to improve his therapeutic effectiveness measurably beyond what he accomplished in the pre-Recovery days of his psychiatric practice.

ANALYTICAL GROUP METHODS

GROUP PSYCHOTHERAPY

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The treatment of disease has been rapidly becoming a more exact science during the past half century. This has been due to clearer concepts of the position which the individual occupies in Society and his reactions to the many stimuli which he must resolve.

Before any progress could be made, two great fallacies had to be broken down and correct concepts substituted for them:

The first fallacy was that Man is merely a physical being. The first substitution for this fallacy was the acceptance of the concept of Man as having a physical *and* a mental phase—the body *and* the mind, a biologic entity. This dualism, however, was scarcely better than the old idea. It was only when the monism, the body/mind, was accepted that real progress was made.

There is a great difference between the two ideas. The concept of a body *and* a mind means that there are two entities, perhaps independent of each other. It was difficult to see how the mind could be treated through the body or the body through the mind, if the body and mind were independent of each other. The break came when it was found that the administration of thyroid extract cured the body and the mind of the cretin. The study of the action of the endocrines seemed to establish the dualism of the body and mind; but the study of the endocrines themselves refuted the generalization. Matter is substance in vibration—neutrons, electrons, etc. Substance cannot be separated from vibration which is a quality of substance. If the vibration changes, the substance also changes—heat changes snow into water, water into steam, through changes in the vibratory rate. It follows that the mind is the vibration of the body and that any change in the vibration of the body (that is, the mind) means a change in the body, and *vice versa.*

There is a complete interaction between matter and energy. Man is body/mind.

The second fallacy was that any man can be an individual free of the influence of other persons. Primitive Man acted independent of restraint, gratified his desires and reduced his visceral tensions without considering the effect of his actions upon his fellows. He was, indeed, an isolationist. The only man of today, however, who can live in that manner is the one who leads a nomadic existence in an isolated part of the world, or the one who has made a flight into a psychosis. All others feel the impact of their fellow men and are modified by that influence. They become compound persons and are represented by the graph: "I / Society. They are individuals as modified by Society. Indeed, they are a part of Society as well as being individuals.

Group psychotherapy is often thought of as a new social mechanism. It is, however, as old as Society itself. Every part of that social organization is, in fact, a group treatment. Schools, literature, newspapers, the lecture platform, music, the theatre, the cinema, bathing beaches, transportation of material and psychic things, government, the law, religion—all social activities are designed to assist the individual to find an outlet for his personal activities in methods of conduct which are acceptable to the Herd. And, finally, when a nation, or people, acting as an isolated individual, conducts itself in world affairs in a manner inacceptable to other nations, that is, acts in a manner intolerable to other nations, the result may be war.

These social conventions—literature, the theatre, law, religion, etc.—are very complex; but they are all designed to assist the individual in working out the problems of his simple, primitive emotional reactions. These mechanisms have been correlated by the Freudian School and its followers. The writer of fiction, for example, motivated by personal emotions, portrays a hero or villain who represents a phase of the author's life; and the reader puts himself in the place of the hero or villain and profits by the example. The actor, seeking an outlet for his exhibitionism, assumes a role and the audience identifies itself with the actor. The present writer once saw an audience in the Florence Opera House rise as a body, hissing and cursing the villain on the stage. In another instance a patient could not witness the daredevil moving pitcures of Harold Lloyd without breaking out in a cold sweat, suffering from palpitation and having to leave the theatre to prevent a physical collapse. The Law tells us what we must do in working out our

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personal desires, and specifies what will happen to us if we do not conduct ourselves in a social manner. The leaders of our churches, having identified themselves with Christ or with a prophet, assume the self-sacrifice of Christ or the prophet and become living examples of moral conduct.

The human emotions are often erroneously thought of as merely feeling tones or timbre. They are, however, as the word indicates, forms of movement, agitated and tumultuous. We think immediately of the clenched fists in anger and hatred. This form of movement is due to the physical phase, a motion within the body. Every emotion is feeling/action and is, in fact, a physico-mental mechanism. They are bi-polar since the vibration of matter is to and fro. They find expression in paired opposites: Love and Fear. They are many modifications of these two, such as joy and sorrow; hope and despair; modesty and exhibitionism; rest and fatigue; and many others. The most important mechanism by which the individual solves his social problems is that of identification. It is the basis of friendship, pity, charity, and of society itself. Also, unfortunately, of shame, jealousy, hatred.—Into this maelstrom the child is plunged; and as he finds expression for his emotions, so is his personality.

Despite the constant efforts of Society to fit the individual for social activities, certain persons are unable to resolve those emotional conflicts which are destructive to them. The environment has become a source of fear in its broadest sense and has forced upon them an adjustment which is periodically or permanently faulty. These are the mental defectives, delinquents, psychopathic personalities, alcoholics, psychoneurotics, acute and chronic psychotics, and other mal-adjusted persons. Some break mentally with a partially successful solution when forced into a new environment for which they have no successful solutions such as marriage or war. It is possible that every man may have his breaking point and be forced out of adjustment when a new and destructive environment is too prolonged. Many examples of this type are being seen among the returning veterans of this War where fatigue, exposure, flying stress, privation, and other debilitating influences incident to war threw the body/mind out of adjustment. They reduced its resistance to the destructive fears of shipwreck, flying hazards, actual combat and all the terrible blitz-krieg and the frightful bombing of World War II.

A certain percentage of these maladjusted persons make an adjustment by natural social routes: through experience, reform schools, education offered

by many agencies, gradual changes in the endocrine systems, Alcoholics Anonymous, religious teaching, and many others. Those who do not adjust make a flight from Society by remaining introverts, withdrawing to shut-in occupations or their homes. The most severe are hospitalized in sanitariums or in mental hospitals. It is for these groups that Society must offer more drastic methods of treatment.

The group method has the following advantages:

(1) Many patients can be treated at the same time.
(2) The patients become socialized.
(3) The difficulties of the positive transfer are less because the lecturer remains more impersonal.
(4) Material which is highly embarrassing and stirs up resistance in individual psychoanalysis, can be presented to the group and be accepted by the patient.
(5) The patients discuss the lecture material among themselves with great benefit.
(6) The patients ask questions and during the discussion before the group many patients will start discussing their symptoms after having refused to divulge them to the physician.

Some comments on the group method may be made

(1) The writer has learned that the patient is "accessible" at all times to the correct method of approach. The analyst or psychiatrist is the only inaccessible person, projecting his own inferiority and inability to understand the symptoms on the patient.
(2) While the early experiences (Freudian psychology) act as the drag back, the real difficulty for the patient is a bar to the outward flow of the libido.
(3) Group training without insight fails. The patient must know about his instincts in order to socialize them.
(4) Insight is the first step toward recovery. But every treatment which stops here fails. Real cure occurs when the patients bring into action the corrected, socialized emotion. The body/mind must be integrated in social activities. Training of the socialized emotion is the second step.
(5) The lecturer starts every talk with the date, place, and purpose of the talk. Important news may be added.
(6) Daily behavior charts of illustrative cases should be kept.
(7) After the 7th lecture, free discussion is encouraged. Before that, it is useless and so obviously an attempt to attract attention that it is resented by the group.
(8) Diagrams representing the flow, suppression and repression of libido are used throughout the course of lectures.
(9) The lecture of the preceding day is reviewed in abstract before each lecture.

The material and arrangement of the individual lectures which is used in part or in whole with various groups is as follows:

(1) Introduction. The fear of the new. Tolerance of other points of view. Geology, the study of the layers of stone on the surface of the earth. The development of the human body through layers. The layers of the mind. The paleontologist and fossils in stone. Repressed experiences, the fossils in the human mind. Self-knowledge is the first step toward recovery. Breakdowns can be prevented and cured. Shame not justified.

(2) The primitive instincts. Bisexuality is a normal condition. Death. The fear of death the basis of all fears. Fliess: male and female cycles. Adam and Eve. Urim and Thummin. Yang and Yin.

(3) Heredity. Discussion designed to break down the belief in heredity as the cause of nervous and mental disorders. Pointed examples illustrating mental conflict as a cause of physical and mental conditions.

(4) The development of primary images of personality; the man-and-woman images. Other images of personality. These images as symbols for masculinity and femininity. The mother and father as symbols for these images of personality. The mother level. The Oedipus complex, abstract of the drama, illustrating bisexuality.

(5) Myths and examples of the Oedipus in other races. Illustrations of the identification of the child with a primary image of personality.

(6) Totemism as an example of racial identification with these images. Analysis of totemism. Examples of totemism in the play-activities of children.

(7) The myth of the Birth of the Hero and The Family Romance of Neurotics, Otto Rank. Examples from life and among neurotics and the insane, and in the play-activities of children.

(8) Analysis of Kipling's "Jungle Stories" showing the Oedipus complex.

(9) Analysis of the same showing the hated man-image. Analysis of Taboo. Examples in the life of the neurotic and insane.

(10) The myths of Echo and Narcissus and other myths illustrating narcissism or auto-erotism.

(11) Physical narcissism. Lecture devised to break down fears and misconceptions as to past experiences. Readings from various authors. The many forms of auto-erotism, exhibitionism, curiosity, etc.

(12) Mental and spiritual narcissism.

(13) The development of the ego-ideal and conscience.

(14) Day-dreaming, its mechanisms and great dangers.

(15) Homo-erotism, its development and influence on the individual.

Examples in mythology. Types: aggressive and submissive. Fear of the man- and woman-images in etiology.

(16) Analysis of the artist and of art. Life of Leonardo da Vinci after Freud's book of the same title. Pictures illustrating conflicts.

(17) Abstract of Dr. E. J. Kempf's analysis of the psychology of the "Yellow Jacket."

(18) The inferiority complex. Reading of a lay magazine story illustrating the feeling of inferiority.

(19) The feeling of sexual inferiority. Psychosexual inferiority, after Ferenczi. Other types of sexual complexes.

(20) The guilt complex. Origin of the various phobias.

(21) The shame complex. Self-consciousness. Erythrophobia.

(22) The inadequacy complex. Fear of failure, ridicule, censure, etc.

(23) The physical reactions of fear. Causes of fear and anxiety.

(24) The training of the child; its transitions and goals.

(25) Psychic complexes and mechanisms. Identification, projection, introjection, projection of blame, criticism, elevation and substitution. Displacement and other mechanisms.

(26) Overcompensation. Its mechanisms and results on a physical, mental, and spiritual level.

(27) Sublimation. Adjustment to the Herd. Altruism. The development of ethics, aesthetics, and morality. The social conscience.

(28) The causes of failure. The sources of success. Habits and their formation.

(29) Thrift of money, energy, and time. The minute the most precious of all possessions. The value of work.

(30) Emotional control and behavior, including the goals of life. The influence of repressed complexes. Self-study and self-analysis. The effect of rage and fear in anxiety neurosis, hyperthyroidism, and epilepsy.

(31) Hygienic living. Alcoholism. Gambling. The responsibility of the individual as a social animal.

(32) Summary and review.

Throughout the course inspirational material is used. "A Message to Garcia" is mimeographed and distributed for reading. Other valuable material is Kipling's "IF"; "How to be a Failure" by Industrial Peace; "Opportunity" by Walter Malone; "Fighter or Quitter" by Grantland Rice; "Invictus" by Henley; "Analysis of the Psychology of the 'Yellow Jacket' ", by Edward J. Kempf; quotations from many sources.

Finally, the writer wishes to quote from his article* published in 1921:

"In conclusion the writer holds the ideal that institutions for the insane

now largely devoted to custodial care, hydrotherapy, etc., should be changed into institutions for the instruction of these patients; that such instruction should aim at directing the instinctive demands, into normal channels aiming at the heterosexual goal; that defectives not due to organic causes, psychopathic personalities, and the morons should be handled in large numbers by this method; that young men in criminal institutions, reformatories, under the care of the Juvenile Courts should be given this instruction, believing that Society owes it to these patients that they be not allowed to stagnate in mental inactivity, and that large numbers could by this method be raised to a sufficiently high level to be of economic value to the community or return to active life, even if on a lower plane. It is further believed that colonies of these patients should be established looking toward this end. Newspapers should be provided and every method used to assist the patient back to reality."

*Lazell, E. W., "The Group Treatment of Dementia Praecox," *Psychoanal. Rev.*, 8: 168, 1921.

GROUP PSYCHOTHERAPY

Louis Wender

Group Psychotherapy is a form of treatment which utilizes a modified psychoanalytic approach with a group of mental patients. The use of this method is not advocated as a time-saver. The use of the method is based on the premise that the patient's early traumatization occurred in a group (his family), that his subsequent social mal-adjustments were conditioned by these early traumatizations, and that the group interaction can be utilized to enable the patient to live out some of his early emotional fixations.

This method is particularly well adapted to an intra-mural setting. It cannot be used in a hit or miss manner. The entire organization of the hospital has to be consonant with this plan and permit for the satisfying functioning of group life. The method is used in conjunction with individual therapy and members of the staff are present at group sessions. The method itself can be described as a modified and active psychoanalytic approach, in which the director of the group becomes the father-image, the nurses become mother substitutes, and the other patients are identified with siblings. These patients remain in the hospital setting for months at a stretch and their common day-to-day experience can be utilized to provide the pattern of a substitute home.

This approach must be differentiated from the many group therapies, in use at the present time, where patients are assembled, given psychological interpretations, permitted to relate their difficulties freely, and gain some intellectual insight and a degree of emotional release. Nor can this method be compared with the technique used in out-patient clinics, where the patients come from different geographical settings and return to their own homes after a session lasting an hour or two.

The approach to which this paper refers is a form of psychotherapy, which utilizes psychoanalytic principles in the handling of a group instead of an individual. The orientation is Freudian, but the therapist assumes a more active role than the analyst in individual analysis.

The patients suitable for group psychotherapy are those who are in contact with reality—psychoneurotics, mild depressives, and even borderline schizophrenics. Real psychotics, hallucinated individuals or hypomanics are unsuitable. It is essential that the patient have normal intellectual capacity. Insofar as possible, groups should be planned so that they are fairly homogeneous in intellectual and social backgrounds. This is essential to enable

the therapist to place the discussion on a level within these patients' capacity

There are certain pre-requisites to the success of this method. The therapist must be a familiar figure to the patients, a working member of the staff. He, in turn, must know his patients and have a real grasp of their histories and an awareness of their pre-morbid personalities. Patients should be invited to the first session but the choice of whether they wish to remain in the group should be theirs. Incidentally, experience over a fifteen year period, has demonstrated that patients are eager to participate and that their attendance is faithful.

The leader of the group must be an experienced psychotherapist, who has a good rapport with his staff and can make this a common professional venture. His manner must be informal and easy, and he must possess skill and the ability to set patients at ease, to enable them to verbalize their problems and ideas, and to relieve emotional tensions in the group.

The group meets in an informal setting and the patients are permitted to relax and to smoke. Sessions are held at regular intervals. These sessions must never be permitted to deteriorate into lectures. Such introductory theoretical material as is presented, should be utilized largely to achieve an attitude of objectivity and non-emotionalism about the whole approach. The presentation of the theoretical material is gauged to the intellectual and emotional composition of the group. If necessary, to make the material more concrete and familiar, one discusses physical disease; its cause, the pathology produced, and the reaction of the human organism to symptom formation. This analogy finds ready understanding and acceptance. It paves the way for the description of emotions and how the individual reacts to the conflicts of conscious and unconscious drives, resistances, early conditioning, sibling rivalries, etc. There is some reference to the unconscious and the channels through which repressed material is expressed, symbolism and the role of dreams in our daily life. Hypothetical cases, embracing some of the features of the patients' own histories, adequately disguised, are presented. Though the hypothetical presentations and the discussion have been planned in relation to a particular individual, the discussion does not focus on him. The therapist approaches this problem generally and evokes discussion from patients less involved emotionally in such a problem. This activates the group. There is a free flow of ideas from the participants, resembling free association, with production of a good deal of unconscious material.

The patients about whose problem the session has been planned is also

drawn into the discussion. He is not aware that the problem is his own, nor are the others. He talks freely at times, shedding a great deal of light on his own problem, expressing repressed hostilities and frustrations, and producing a good deal of unconscious material. The spontaneity and tempo of discussion brings forward much revealing material from the other participants. In this way the leader and the other psychiatrists learn each individual's reaction to some problem, his defenses and resistants. The participation of the staff is valuable because they observe their own patients when the latter are not on guard and because the group sessions serve to stimulate the production of material and enrich the content of individual interviews.

No patient remains withdrawn from the group discussions. Sooner or later the patient becomes involved. The freedom and spontaneity of other participants, with whom the patient identifies, overcome some of his resistances. The observations which the leader and staff make are every bit as valuable as the actual material produced, since they are able to gain some clues to the patients' resistances and blocs. The leader's role is that of an arbitrator and observer. He should permit free and easy interchange of ideas among the participants. Thus, aggression is released and the individuals give evidence of re-enacting some of their early family conflicts. He should also encourage the staff members to participate and to give some of the interpretations requested by patients, as this helps to integrate the group.

As the group becomes more integrated, tensions diminish. The individual begins to view his problem as part and parcel of the general difficulties of human adjustment. Hostilities, habits, ideas and attitudes that he regarded as shameful, repugnant and peculiar to himself, lose their intensity and secrecy, when viewed against the background of similar problems on the part of his fellow-patients and universal human adjustment. He begins to feel that the group—the society in which he finds himself—is not perfect, and that frustrations and inferiorities are not uniquely his alone.

In evaluating group psychotherapy, one must bear in mind that there is no exclusive method that is successful with all kinds of patients. There are many patients for whom group psychotherapy provides a realistic approach to their difficulties. The entire experience of hospitalization can be utilized as a process of enabling people who failed in their adjustment to a larger work to re-test themselves through learning to live in a smaller one. Obviously, they failed to make the hill of adult adjustment in "high" gear. The re-living experience, enables them to start off again in first gear

and to make the transition to "high". The hospital experience can be adapted to enable them to re-integrate. They have their own organization, elect their leadership, and make adaptation. In a limited way they learn to re-adapt to group living; to agree and disagree; to step on people and to be rebuffed; to express resentments; to accept frustration; and to derive some satisfactions.

The question is frequently brought up whether a group like the one described possesses special characteristics beyond those of the individuals comprising the group, and whether such characteristics further or deter the patient's recovery. The experience in the armed forces tends to support the idea that the influence of the group furthers the recovery. Personally, I am in agreement with Freud, who in "Group Psychology and the Analysis of the Ego" said that "love relationships (or emotional ties) also constitute the essence of the group mind". In my opinion, the group acts toward the re-awakening of the libido to outside channels. The neurotic has become introverted and engrossed in himself because of his failure to obtain libidinous gratification from the outside. Group psychotherapy can provide a medium for re-channeling of libidinous drives to outside objects. The patient becomes interested in his fellow-patient and tries to help him. He develops a sense of importance, of being needed. Because he can discuss someone else's difficulties, his own become lessened. He becomes interested and his introversion diminishes. Perhaps he forms an attachment to the other patient whom he tries to help, thus releasing his own narcisstic libido. Gradually, like a child, he discovers the world about him and the satisfactions which he can derive from social adjustment.

Some of the patients who received group psychotherapy have been followed up for ten or twelve years. Several hundred of them have carried on an active mental hygiene program through an organization of their own. While few of them can be cited as brilliant social or economic successes, the fact is that many of them have made and maintained a social adjustment consistent with their status and capacities.

NEWER VIEWPOINTS IN THE APPLICATION AND RESEARCH OF GROUP PSYCHOTHERAPY*

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Our group psychotherapy (2, 3, 5, 7, 8, 9) was devised for the treatment of the skilled, social-democratically organized, unionized, in their private life more or less settled workers, who rather were small order-loving bourgeois, conscientious providers, faithful husbands, owners of small savings accounts, trying hard to give their sons and daughters insurance to cover education, marriage, etc.

The accident occurs as a very characteristic event in the life of a man, who from his apprenticeship to his forties in many hard and laborious years, has not only acquired a particular skill but has built up in himself a complete motivation toward work and life, comprising both the eight hours of his working day and his leisure. The sudden breakdown in the traumatic neuroses touches off piled-up anxieties and causes them to break through the dams of insurance and reassurance, built up in union contracts, party politics, etc. In the neurosis, the worker again becomes isolated and the neurosis is the class struggle of the isolated individual who has felt subconsciously for quite a time that the political and economic power of his class is not sufficient and that there is no true compensation for the insecurity of his life and the incessant endangerment of his most precious possession, his working ability and capacity.

It is this common background hidden in the subconscious which our group psychotherapy of the social neuroses has drawn to the fore. (See Eliasberg, 10, 4.) It would have been wrong from the outset to treat the social neurosis of the skilled worker like that massive conversion hysteria of the unskilled worker. Even if they are present, the disease of the former does not basically consist of conversion symptoms and it is no use fixing the attention of the patient on pain, weakness, dizziness, feelings of fatigue, trembling knees, etc. although the social psychological meaning of these symptoms as losing the ground under one's feet may well be made understandable to the patient. But the main thing is that there is a disorder in the tangible and particularly in the abstract social relationships and

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*Because of space limitations the introductory three pages of this article are not included.

those anxieties have piled up just because of these two disorders. (Elias-berg 6.)

We all have to orient ourselves upon our fellowmen, whom we see, hear, smell, rub cheeks with, and on the other hand, upon statutes, observances, laws, rules, and regulations.; The worker may hate the foreman as a person but may feel that it is rather the rules which enforce a certain course of events from dawn to dusk. It is absolutely not feasible, as well-intentioned companies have tried to do, to reform only the tangible relationships, to advise the foremen, the engineers, to be polite and nice to the workers, to make the surroundings clean and healthy, to have recreation facilities, etc., and to leave the abstract relationships on which the feelings of security needs rest, unchanged. It is necessary to find that proportion of tangible and untangible rela-tionships, that proportion of agreeable personal relationship and co-ercion which is the appropriate one at a certain time, in a certain place for a certain population of workers.

Practically we have proceeded in this way. Between two to three hours were devoted to establishing a mutual acquaintanceship between the patient and his doctor. This can be done clinically, but it is not necessary in each case to hospitalize the patient. We have experiences with both hospitalized and non-hospitalized series and no important difference has been observed which would prove that hospitalization is superior for the treatment of such cases. While the contact between the psychiatrist and the patient is estab-lished, and of course a thorough physical examination carried through, he is being acquainted with the seminar. This can be made easier if such seminar is already known among those who are in contact with a workman's sickness or compensation fund. It does not matter that the whole group should be an "in group" for the total period of the seminar. Newcomers will easily take up the thread, provided the general homogeneity of the group is preserved. It has proven valuable to discuss problems of the economic, social, political, industrial, and maybe organizational and private life of the workers.[1] As soon as possible the members of the seminar them-selves should deliver short talks and this should be discussed by the group with a sociologically and economically trained psychiatrist as the moderator. It is not desirable that the psychiatrist, instead of being a moderator, acts as a lecturer. In such a case, failures may be anticipated, as was for instance the case of the Vaterlaendischer Unterricht in the first World War, which

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[1]Ten years later, P. Schilder has also found that the analysis of ideologies can be a psychotherapeutic method, especially in group treatment (11, 12).

consisted of lectures given by officers for enlisted men and non-coms who
had to sit by in silence. They considered the whole thing as just one
more branch of G.I. service and were by no means disposed to accept it.
(Eliasberg 6.) In other words a factor which must be utilized as soon
as possible is the spontaneous activity of the members. This activity in
a statu nascendi group is very apt to raise the standards of the group as
a whole and the individual members, quite differently from what the older
mass psychologists, LeBon, Tarde, Taine, and Sighele deemed to be the
basic tenet of the lowering of the individual by the group. Shared experience
(Abstraktion durch Ausbreitung im Personnenkreis) as is known since the
time of Socrates, is one of the foremost methods of learning, abstraction,
and social orientation. The mechanism that works in such groups is cer-
tainly not only one of the relationships between the members, but also
of transference to the moderator, the treating physician. Nothing must
be avoided by the latter more than class orientation. His neutrality in
questions of the relationships between companies and unions must be defi-
nite. Class struggle as such cannot be abreacted and is therefore not subject
to psychotherapy. We have already mentioned that while the turnover of
manpower in the seminar is not troublesome it is a result of our experience
that class in homogeneous groups cannot be burdened with psychothera-
peutic purposes in social neuroses.

It is, incidentally, interesting that the psychotherapeutic groups which
this author directed have also proven strongly resistant to the rising tide
of the Hitler propaganda. This leads us to the not yet tapped value of
the statu nascendi, as well as pre-existing groups for experimental purposes
and research.[2] The dichotomy of Moore (13), more analytic or more
repressive-inspirational groups, is for the time being no more than a working
hypothesis.

The factors that should at present be thoroughly examined are those
of self-demonstration, of acting out of conflicts and problems, etc. It
certainly plays a part in the success of our groups that the participants
have to get up, to verbalize what they mean, to speak up for their convic-
tions. The technique of psychodrama will allow of a new approach to these
problems (14). It might especially be expected that the concept of the auxili-
ary egos, as introduced by the psychodramatic theory will prove valuable for
the improvement of both practical results and theoretical insight.

Any group that wants to function as such must become articulate

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[2]See J. L. Moreno's exposé of Group Psychotherapy, in this volume on p. 77.

through symbols. In education and propaganda this is old wisdom and because this is so modern propagandists have often been prompted to steal symbols and to try and do new tricks with old symbols. Whether or not such plagiarism pays, it shows that there is a belief that symbols create symbolism and make men into wax so they can be reshaped.

It is certainly not the aim of psychotherapy to take away the self-determination from neurotics. Nevertheless, symbolism in a psychotherapeutic group is a topic that has been neglected fairly as much as there is a need for it. We will not create the symbolic state of mind through mere signs which we call symbols but we should pay attention to the social psychological and social economic background of the traumatic neuroses on the one hand and the pre-existing symbolism thereof. We might also think of creating new symbols if we feel sure we have a good working knowledge of that background. See for this Bakke (1). As it is at present, we will have to do much research in this field but the general idea holds true for propaganda as for psychotherapy: first advertise, propagandize, symbolize the need and the idea and then show, advertise, and sell the "goods".

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SOME THEORETICAL ASPECTS OF GROUP PSYCHOTHERAPY

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A theoretical discussion of group psychotherapy, at the present stage of development, is a hazardous undertaking. I assume this risk with the utmost humility. While it is true that fools will go where wise men fear to tread, it is likewise true that, were there no fools, there would also be no wise men. Therefore, with chastened spirit, and with full awareness of the relative dearth of controlled clinical and empirical data in this field, I shall attempt a short discussion of some theoretical principles. In doing so, I shall lean heavily on my own clinical experience with this form of therapy, which involved group treatment of Veterans[1] at the Red Cross and group treatment of disturbed adolescents in my private practice. This background inevitably implies some wide gaps of factual knowledge, and perhaps some personal prejudices as well.

It should be understood unequivocally, at the outset, that there are numerous and diverse forms of group psychotherapy. There are all types and levels of group psychotherapy, just as is the case with individual psychotherapy. The quality and patterns of emotional contact between patient and therapist vary accordingly. Such contact may be predominantly on the supportive level, release level, or insight level, or any admixture of these. It is only logical that there should be these different levels of treatment since the therapeutic aim, the role of the therapist, and the actual treatment techniques must be specifically accommodated to the special needs of distinct personality types, the problems arising out of the patient's social situation, and also to the particular environment in which the therapy is conducted.

The specific level of therapy and the treatment techniques applied in a given case reflect the therapist's aim, which may be: 1) to improve the adaptation to a specific social situation; or, 2) to relieve certain forms of acute emotional distress with a view to restoring the pre-existing personality

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[1]Group Psychotherapy with Veterans, presented before the Assn. for Psychoanalytic and Psychosomatic Medicine, Apr. 3, 1945. Also presented in condensed form before the Amer. Soc. for Research in Psychosomatic Problems at N. Y. Academy of Medicine May 11, 1945.

balance; or, 3) to produce a basic change in personality organization; or, 4) any combination of these. Such aims determine the proportionate degrees in which support, release, reality testing and insight are emphasized in the therapeutic experience.

In accordance with these differences, the group may be small or large. It may be homogenous or heterogenous. It may be composed of similar personality types presenting a common psychological problem, or may be composed to some extent of contrasting personality types. The dynamic equilibrium of the group can be controlled by mingling timid and aggressive types of patients, or on occasion by including a special stimulus in the form of a particular personality type playing a special emotional role in the group. Still another variable factor is the social setting in which therapy is conducted. Depending on whether it is conducted in a hospital, in an out-patient situation, in a military environment, in a civilian community, or in a prison, the therapeutic experience carries a different meaning to the patient.

All these variables result in differences in treatment method. The existence of these differences renders the task of extracting some useful general principles more difficult. I have neither the space nor the qualifications for assaying the significance of all these variables, but I do wish to emphasize the validity of differences in method based on these variables.

In any case, when group therapy is indicated, we have to ask the further question, what special form of group treatment is appropriate, both in relation to the unique needs of the patient, and the unique features of the total life situation surrounding the patient.

Group therapy is, first of all, a special kind of social experience. It may be exploited for purposes of social re-education of attitudes and emotional drives, in which case, mainly, the conscious organization of behavior is modified. Or, on the other hand, it may go deeper, stimulate release of unconscious urges and emotions and catalyze new insight into the meaning of these deeper experiences. In this case it is a treatment in depth simulating in quality some of the processes involved in psychoanalysis. In this connection there has been some confusion in the literature as regards the terms "group work" and "group therapy." Some writers have claimed identity between these terms and some have claimed a basic distinction. For purposes of clearer orientation, I believe it is useful to restrict the term "group work" to processes of social re-education, and reserve the term

"group psychotherapy" for depth treatment involving a systematic approach to the total personality, involving access to unconscious mechanisms, and bearing the potentialities for basic reorganization of personality.

Bearing in mind these numerous differences in aim and methcd, I should like to indicate briefly the features which characterized my method of group treatment of Veterans. These veterans represented a mixed group diagnostically. Included in the group were men with social maladaptation, character disorders (neurotic characters and schizoid personalities), psycho-neuroses, and psychosomatic disorders. The group was restricted to from four to eight patients. This limitation was imposed in order to insure ade-quate emotional contact and continuity in the inter-personal relationships, both patient-patient and patient-therapist relationships. In the main there was sufficient similarity in the conflict patterns present in the individual patients to insure a dynamic basis for the development of empathy and identification. To this extent there was homogeneity in the group. Beyond this point, however, there were numerous individual differences in person-ality, which I considered desirable because it provided an inexhaustible reservoir of challenging stimuli to the social reactions of the members. I should add one point: the emotional equilibrium of the group was bal-anced by including some timid, and some aggressive personalities.

My therapeutic aims were concretely the following:

1) To provide a continuous flow of emotional support through the group relationships.

2) To activate emotional release in the area of specific anxiety-ridden conflicts; in particular, to encourage the release of pent-up aggression. This meant utilizing group psychological influences for the selective reenforce-ment of some emotional trends and the dilution of others.

3) To reduce guilt and anxiety.

4) To provide opportunity for the testing of various forms of social reality as personified by individual members of the group, the therapist, or the group as a whole.

5) To provide opportunity for the modification of the concept of self in the direction of increased self-esteem, and recognition of constructive capacities. This in turn tends to increase the acceptance of other persons and tolerance for frustrating experience.

6) To foster the development of insight arising from an actual living out of emotional drives in the context of the multiple inter-personal rela-

tionships within the group. The technique of interpretation was employed only when the expression of specific emotional trends was sufficiently solidified.

I wish here to underline one significant point, namely, that the unique dynamic characteristics of group living impose specific modifying effects on all partial therapeutic processes, such as we know them in individual psychotherapy. The processes of emotional support, release, expression of unconscious tendencies, reality testing, resolution of guilt reactions, and finally, the acquisition of new insight operate somewhat differently in a group.

I introduced the Veterans to this new experience by a brief statement outlining the aim and the method of this form of treatment. Essentially this was as follows: all the men had been soldiers but they were now experiencing difficulties in restoring their place in their families, communities, jobs, and in their social life, often in their love life. All of them were experiencing some emotional suffering. Our purpose in coming together was to freely discuss their problems, their confusions and anxieties, and, to attempt through mutual help to bring about some improvement. The patients were asked to be completely candid, and to express their difficulties spontaneously.

They responded by unburdening their personal problems, frustrations, and fears. They released their pent-up feelings, often acting them out with a high degree of freedom. They expressed dramatically their wishes and their hostilities. Their conflicts became more sharply defined; the related guilt feelings and anxieties were clarified. They used the group experience as a sounding board for testing the real meaning of their impulses, and the validity of their particular concepts of social reality.

The activity of the group was patterned motivationally by the patients' perceptions of the purpose of the group experience. The therapist personified this purpose, which was to solve human problems, and lessen emotional suffering. Certain dominant attitudes emerged which conditioned the "group atmosphere." This was characterized by a feeling of belonging, a wish to receive and give emotional support, a tolerance of differences, a tolerance of weakness, of conflicting emotions, and a mutual striving for better adaptation.

The group became something akin to a men's club or fraternity. The relationship of patient to therapist catalyzed patterns of conflict reminiscent

of son-father relationship. In this connection, varying reactions to the symbol of authority were activated. The members of the group felt each other as brothers. Corresponding patterns of loyalty and competition emerged.

Of tremendous importance to these men was the security of belonging. Because of their dependent tendencies, the need to be accepted by the group was quite prominent. This was especially conspicuous when the men had no close family ties and felt emotionally and socially isolated. They sought a dependable social reality which all too frequently in their real lives was lacking. Because of this lack, their social values were often confused. The more aggressive personalities in the group activated the more timid ones. The passive, submissive patients attached themselves to the stronger ones. The weakness of some patients invited sharp attack by the more sadistic ones, or led to veiled flirtations of the homo-sexual type. The retiring patients envied the more exhibitionistic types, and sought vicariously to live out their experiences through others. This dynamic interplay provided an effective basis for therapeutic exploitation.

In this process of spontaneous group discussion, inadequate or stereotyped explanations of motivation were challenged. Gradually the layers of evasion, defense, and rationalization were removed piece-meal so as to expose the real nature of the reaction. This permitted a clearer view of the underlying emotional trends and related anxiety patterns. Patients often interpreted to each other the real meaning of their behavior. Sometimes this reflected a genuine wish to help the other person; sometimes it represented merely a sadistic attack, by way of showing up another man's weakness in order to avoid the necessity of exposing one's own.

It is imperative that such attempts at mutual therapy be controlled and directed by the therapist in order to achieve the best results. In the role of therapist, I participated actively in these discussions. I felt the necessity for stimulating empathy between patients, and also for controlling aggressions in order to preserve the essential unity of the group. This might be called the stabilizing function of the therapist. I played a role in catalyzing the release of repressed feeling and channellizing this release toward a more accurate understanding of the patient's emotional drives. I employed the technique of interpretation only when the emotional trends had become clearly crystallized..

In this particular form of group treatment, I gradually evolved a few

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tentative hypotheses, which I am ready to modify with wider experience. These are as follows: group psychotherapy neither substitutes for, nor competes with, individual psychotherapy. It is an independent method having certain unique dynamic characteristics of its own, and serves special purposes. The interpersonal relationships in the group are more realistic than is the case in individual psychotherapy. The group experience offers direct gratification of certain emotional needs. Group dynamics are more specifically adapted to "externalized" patterns of emotional conflict, namely, those conflicts in which the struggle is mainly between the person and his environment, rather than between two opposing forces within the psyche. The group experience heightens the expression of emotional drives which can be experienced in common with others. It fosters a living out of emotional experiences and tends to release tension on a motor level. For adult patients with serious intrapsychic distortion, it is either contra-indicated or represents, at best, a partial therapy.

Having come to group psychotherapy through my experience in psychoanalysis, I have been impressed with certain basic differences in the two methods. In this brief report I can only suggest the direction in which these important differences lie. Dynamic trends emerge in the group situation which either are not present in a two-person relationship, or at least not in an identical form. Emotional interplay between two persons, such as in psychoanalysis, provides the potentiality for a social relationship, but it requires a group of three or more persons to provide a foundation for an organized social order with dominant aims, ideas, values, and patterns of interpersonal experience. Of necessity, this fact influences in specific ways the application of psychotherapeutic principles to a group setting.

In psychoanalytic therapy the patient relives his inner struggle between his pleasure drives and his anxieties. In this struggle the analyst gives the patient emotional support, and wittingly or otherwise, takes the side of the patient's unconscious drives in order to facilitate their release. Simultaneously, he endeavors to relieve the pressure of conscience and the inhibiting effect of reality. In this process, it is part of the analyst's role to personify reality, both in the context of the patient-therapist relationship and in the context of the wider outer world as well. Since the patient is unsure of his own standards, he seeks to rely on the presumably more valid reality standards of the analyst. But this special role of the analyst in personifying reality does not always work satisfactorily. In the analytic situation there

is no actual social reality against which a patient may measure the impact of his impulses. It is in this respect that group psychotherapy offers a special advantage.

In the group situation, the therapist deals with the same three levels of psychic functioning as in analysis, namely, unconscious drives, conscience reactions, and reality, but the balance of these forces is different from what it is in individual psychotherapy. In the group setting, the impact with concrete forms of social reality is immediate. The patient's accommodation to social reality can be shifted or modified but can never be avoided entirely. In psychoanalytic therapy, in contrast, contact with social reality can sometimes be temporarily subordinated or minimized. In a group situation, adaptation to social reality is a constantly changing phenomenon. The immediate social reality is a fluid one, because it is variously personified by one patient or another, the group as a whole, or by the therapist.

Moral reactions and guilt patterns vary tremendously in the group setting. The less rigid types of guilt reactions can be considerably modified through group psychological influences.

Access to unconscious forces is a variable phenomenon in the group situation. At times, it is possible to effectively modify unconscious mechanisms; at other times, contact with such unconscious forces is difficult to sustain, and therefore, difficult to work with systematically. In this respect, individual psychoanalytic therapy has a definite advantage since it is a means for systematic modification of unconscious behavior.

SUMMARY AND CONCLUSIONS

Group Treatment can be conceived both as social re-education and as a special form of psychotherapy. It is a special variety of real social experience, which can be exploited to correct social (reactive) disturbances, personality disorders of some types, and also, in a positive sense, promote personality growth. The interpersonal relations in the group approximate experiences in ordinary social life. The therapist is a more real person than in the individual therapy situation. The group provides emotional support for its members. In this setting social reality is a fluid entity, personified at various times by individual members, the therapist, or the group as a whole. Group dynamics offer opportunity for free impact between repressed emotional drives and varied forms of social reality, through which the patients may test the nature of these realities and achieve better understanding of

their impulses. Guilt reactions of the less fixed types can be effectively modified. Access to unconscious mechanisms is more variable and less predictable than in individual therapy. At times, therapeutic contact with unconscious forces is effective, at other times, difficult to sustain, and in such instances, the therapeutic results are less reliable.

The form of group treatment I have described offers a useful approach to some types of social maladaptation and emotional disturbances of recent origin. It is also a valuable means, within limits, of modifying socially inefficient defense patterns, and for the analysis of maladapted character traits, for example, a chronic tendency toward failure, a drive for perfection, and a tendency to emotional isolation. Such group dynamics are better adapted to "externalized" patterns of conflict. In addition, group influences can be used to encourage sublimation and reaction formations of a socially useful type.

To summarize, Group Therapy is an independent method; it neither competes with, nor substitutes for individual therapy. It is a more real experience than individual therapy. It is less bound to the irrationalities of the unconscious and is weighted on the side of allegiance to social reality. It is only a partial therapy for the more serious personality disorders. Its powers are sharply limited with personality disorders having deep unconscious roots. Its greatest effectiveness lies in the area of reintegration of ego patterns with consequent improvement in the level of social functioning. For some disturbances of personality it may be usefully combined with individual therapy.

PSYCHODRAMATIC METHODS

PSYCHODRAMA IN AN EVACUATION HOSPITAL

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138 Evacuation Hospital, U. S. Army

Introduction

This is a preliminary report concerning the psychodramatic work in an evacuation hospital. The 138 Evacuation Hospital, a 400 bed installation, was stationed for several months in Trier, Germany, in a building which had formerly been a civilian hospital. Because of its good facilities, it was made a center for neuropsychiatric cases, and the surrounding hospitals evacuated their cases to us. We had a daily average of 30 psychiatric patients, none of whom was allowed to remain more than five days.

The technique of J. L. Moreno was used, but our work was performed under the improvised conditions found in a theater of operations. No stage or theater was available. We did our work in our office, a large room about 20 feet square, furnished with a desk, a table, one couch, a closet, and several chairs. The floor was covered with a carpet, which made it easier to reenact scenes that had originally taken place on the ground.

A history was taken of every patient, and the Kent EGY intelligence test was given routinely. It was surprising to see that even soldiers whose IQ's placed them in the moron group could be easily induced to act. No narcosynthesis with sodium pentothal or sodium amytal was used. Because we had no time to reenact systematically the entire history of each patient, we limited ourselves to reenacting the highlights of each case.

Before each scene, according to his level of intelligence, the patient was given a short talk explaining what we were planning to do, telling him not to be afraid of the audience who would keep all that transpired confidential. The subject was asked to describe in detail the locality and to identify the position of each landmark with some object in the office. In this way the corner of the closet would become a street corner behind which he would see dead people, our desk would become his commanding officer's desk, and so forth. It was surprising to see how much importance the patients themselves attached to the proper arrangement and re-arrangement of the furniture to fit the original situation, and how much it disturbed them to see anything out of place.

Doctors, nurses, and wardmen acted in supporting roles helping to re-create the characters involved in the original situation (auxiliary egos). In a few instances *the original partners* were available to act as auxiliary egos.

Many patients have a tendency to be narrators rather than actors. We induced them to act as much as possible. No script was used and all acting was impromptu. After each session we had a short discussion and analysis with the patient, trying to tell him what we had been able to learn and how it helped to understand his case.

No strict and uniform technique was used. We varied our procedure to suit each individual situation.

THE DRAMA AND OTHER FORMS OF PSYCHOTHERAPY

Let us consider other forms of psychotherapy and their relation to the drama.

HYPNOSIS

In hypnosis a scene can be suggested to the patient and he can be asked to act in a certain role. For instance, he can be told that he is in a garden picking flowers. The subject will rise from his bed as if he actually saw flowers around him, and he will go through the motions of picking imaginary flowers. Upon being told to give them to the hypno-tist, he will pretend to do so, stretching forth his empty hands as if to make a gift. In other words, we can consider hypnotism as a dramatic perform-, ance of the person who has been hypnotized.

It has long been a question whether the subject is really asleep. Experiments by Jenness and Wible in which blood pressure, respiration, and other vital functions of the patient during hypnosis were compared with those during sleep, showed that the hypnotized person is really awake. He is engaged in psychodrama without knowing it. When we ask our-selves whether hypnotism is a suitable form of psychotherapy insofar as the psychodramatic procedure is concerned, we must realize that it has two strong drawbacks.

First, not every person can be hypnotized. It is easier to tell the sub-ject to pretend to be picking flowers than to go through the same perform-ance via hypnotism. And secondly, the role of sleeping sometimes inter-feres with the acting. Some people will be so deeply hypnotized that they will not get up when told that they are in a garden, but will continue to lie down while reaching into the air as if picking and handing you imaginary

flowers. Others will walk around with their eyes closed and their hands outstretched, the way they imagine a sleepwalker should act. Obviously, all this interferes with the psychodramatic action which we want the patient to perform.

PSYCHOANALYSIS

Psychoanalysis has retained from hypnotism the position of the patient. He reclines, is asked to relax and not to move. There are far more restrictions and inhibitions than in hypnotism, in which the patient has freedom of movement once he has been hypnotized. All associations are on a verbal level only.

PSYCHODRAMA

In the psychodrama, the process on the stage has *all dimensions*. Some people are not very skilled in expressing themselves by means of the spoken word, but often a slight movement of the body, like bending the head or taking a step backward, can mean much more than words can express. Associations can be brought back in this way which would be impossible to recover by other methods. We have therefore, in the psychodrama, a method for the breaking of amnesia far superior to any technique on the verbal level. If we reconstruct the locale in the mind of the patient by suggestion, then give him freedom of the stage and such auxiliary egos as may be required, he will suddenly remember a continuity of events which otherwise seems to have passed completely out of his mind.

In psychoanalysis a very important factor in the treatment is the development of *transference*. It takes a long time before the physician assumes for the patient the requisite auxiliary identity, and it is important that after a certain period this transference should be broken in order to achieve a cure. We can see that such a devious approach is far surpassed if we suggest to the patient directly that he accept the auxiliary ego in his assumed role. The patient understands that this is only an imaginary function for a limited time and that as soon as the session is ended the auxiliary ego assumes his real life identity. We can assume many different roles which are important in the person's problem, and we can break each as rapidly and as easily as we created it. If at all possible the original characters in the interpersonal problem can be asked to appear on the stage and to act in their real identity. The physician does not need to assume any identity at all, merely directing the drama.

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NARCOSYNTHESIS

In this war this method of psychotherapy has come very much to the fore. Sedatives are used to overcome the resistance of the patient in revealing his repressed traumatic experience. In Grinker's excellent book, *War neuroses in North Africa,* we see that under the influence of drugs such as sodium pentothal, patients often relive battle experiences in a very dramatic fashion. They crawl on the floor as if they were dodging bullets overhead; they go through the motions of digging a foxhole, etc.

Although some of the sedated patients will readily get up and act, others will be too drowsy because of the hypnotic and will continue to lie down, giving only a verbal account of their story. The chemically induced sleep here interferes with their acting just as the suggested sleep is a handicap in hypnosis. Also, the fact that we might have to keep the syringe in the patient's vein to regulate the depth of the narcosis interferes with his freedom of movement. We think it is far better to ask the patient directly to reenact the traumatic experience. Although he might be resistive at first he soon warms up and is carried away on the stage and we can reenact his past far better than if he were half asleep from a drug.

GROUP PSYCHOTHERAPY

The term "Group Psychotherapy" introduced by Moreno having recently become popular, has been used so loosely that its meaning has become ambiguous. Most people regard it as a form of mass treatment in which several subjects with similar problems can be treated simultaneously. Technically, group psychotherapy can be accomplished by various means, such as lectures, group discussions, and psychoanalysis in groups. The psychodrama can be used for such mass treatments, because it is easy to assemble an audience suffering from similar problems. Either a "prepared" psychodrama can then be performed for their benefit or they can watch a patient treated on the stage with a condition similar to their own. A cathartic process takes place in the audience as they watch the proceedings on the stage (catharsis of the spectator).

It would seem that the psychodrama deserves to be considered as the most advanced form of group psychotherapy for another and even better reason. It is the only form of treatment known to date in which the maladjustments of a group of people can be treated at one time. The other forms of treatment such as psychoanalysis, treat only the maladjusted individual, the

patient. The analyst for instance pays attention only to the child in the Oedipus situation, neglecting the parents who come into the picture as verbal shadows only. The psychodrama permits placing parents and child opposite one another on the stage. In the same way if there is a conflict between husband and wife, officer and enlisted man, both can be brought on the stage at the same time. In theory there is no limit to the number of people who can participate in such a situation and each one of them will be able to participate in all three forms of catharsis. (See below).

What are the therapeutic mechanisms of the psychodrama? They are Materialization, Catharsis, Insight, Training and Adaptation.

1. MATERIALIZATION. The psychodrama gives the mental patient an opportunity to give *materialization* to his imaginary world. The outcast, whose ideas were laughed at and rejected, gains a new feeling of acceptance and self-assurance. The theatre will give reality to pleasant phantasies, providing the patient with a wishfulfillment. It also will give a crystalization to vague fears and anxieties. These now gain substance and reality, so that the patient can face them, struggle with them, and overcome them.

2. CATHARSIS. Aristotle has formulated the concept of catharsis as a process which takes place in the mind of the spectator of a drama. Moreno has elaborated on it and distinguished three forms of catharsis: The first form of catharsis takes place in the author, the creator of the drama. In writing the play he gets many things "off his chest." The next recipient of catharsis is the actor who interpolates his own experiences into the role which the author created. The third recipient is the spectator who experiences a catharsis in the Aristotelian sense.

In the psychodrama the patient is the recipient of all three forms of catharsis at one time. He is the creator, the actor, and the audience in one person combined, thereby deriving a maximum benefit.

3. INSIGHT. The psychodrama, by dramatizing the highlights of each case, provides a synopsis and panoramic view to the patient of his own difficulty. This, with the discussion following each scene, gives him an insight into the mechanism of his illness.

4. TRAINING AND ADAPTATION. The security of the stage provides an opportunity for training. The patient knows that he is safe in the imaginary world in which no harm or ridicule can come to him. The confidence acquired on the stage can then be carried over to real life.

CASE HISTORIES

CASE A

BRANCH OF SERVICE: Cavalry.

PLACE OF BIRTH: North Carolina farm.

AGE: 30.

OCCUPATION OF FATHER: Farmer.

FAMILY HISTORY: Mother died when patient was very young. Patient had five brothers and sisters, all dead.

HOME LIFE: Patient's father remarried, and the patient's stepmother treated him well.

EDUCATION: Only first grade was completed, because the patient had to begin work at an early age. He is illiterate, except that he can sign his name.

CIVILIAN OCCUPATION: Odd jobs, mostly on farms.

DATE OF INDUCTION: April 6, 1942.

ARMY LIFE: Private first class; rifleman; in E. T. O. five months. In combat in Germany about one month.

COURT MARTIAL: One for drunkenness.

MARITAL HISTORY: Married and happy. One child living, one dead.

SOCIAL DISEASES: Denied.

ALCOHOLISM: Patient states that he gets drunk about twice a year, when someone gives him whiskey. He never buys whiskey himself.

DRUG ADDICTION: Denied.

CIVILIAN ARRESTS: Only once, for speeding.

KENT EGY TEST: IQ 50. MA 7½. Moron level.

PRESENT ILLNESS: Patient states he has been hearing voices for the past six weeks. The voices moan and groan, but he can not make out what they say. "It is the guy I killed. I see him too." The patient was referring to an incident about six weeks previously when he had been on guard duty on the Rhine.

A German soldier tried to come upon the bridge guarded by the patient, who had to shoot him. Although hit twice in the chest, the German tried to get to his feet. Another American soldier on guard with the patient, shot him down. The patient said that although he had killed six men in combat, this was the only one that bothered his conscience.

PSYCHODRAMA: The crucial scene in which the patient had killed

the German was recreated with much realism. A ward man played the role of the German soldier, crouching and approaching the patient, and after having been "shot", writhed on the floor—moaned and groaned. The patient said, "Please don't do that. That is how he looked when he died. I can see him in my sleep, on guard, or whenever I am alone. I sit down and wonder if that man will ever get off my mind. He just walks across the road in front of me. He never talks, but just moans and groans."

The ward man got up, walking in front of the patient who shut his eyes. After the session was over, the patient was breathing hard and was very much affected. The same episode was repeated on several successive days and the patient gradually lost his fears. He was constantly afraid of finding bodies in the hospital, say, in the basement under the ward. So we initiated a program of training to familiarize him with dead bodes. We acted out several scenes in which an assistant played the "body", making the patient touch the body, handle it, turn it around, etc. At one time the patient was placed in the role of an undertaker. At first he showed great reluctance to touch the "body" but we pointed out to him that he was only an actor. In time the patient overcame his fear of the dead, and thus received beneficial training.

An interesting aspect of the case is the manner in which the patient at first carried on the dramatic situation after he left the office and avoided the auxiliary ego, the physician who had played the "body".

He also developed a fear of the office, the room in which he had seen the bodies. Observing this, we incorporated into our treatment a scheme to help him to overcome his fears. We had the auxiliary ego frequently visit the ward, walk over to the patient, smile and shake hands.

We also placed the patient in the role of a father and an auxiliary ego (the nurse) in the role of a child afraid of ghosts. The patient had to comfort the child and tell her that there are no ghosts.

DIAGNOSIS: Psychoneurosis, anxiety state, severe.

PROGRESS: Improved.

DISPOSITION: Evacuated to a general hospital.

CASE B

BRANCH OF SERVICE: Combat Engineers.

PLACE OF BIRTH: New Jersey.

AGE: 46.

OCCUPATION OF FATHER: House painter.

FAMILY HISTORY: An uncle ("He looked like me.") suffered from a mental disease. His father was a drunkard.

HOME LIFE: Patient's father, a drunkard who died last year, used to "beat the hell out of" the patient who often had to bring him home because he was so intoxicated that he could not walk.

EDUCATION: Completed the eleventh grade, after having had to repeat the second and the seventh.

CIVILIAN OCCUPATION: Steeplejack, painter, factory worker, mechanic.

DATE OF INDUCTION: November 11, 1943.

ARMY LIFE: Private in combat engineers; in E. T. O. since December, 1944. In combat two months.

COURT MARTIAL: None.

MARITAL HISTORY: Happily married, but has no children.

SOCIAL DISEASES: Denied.

ALCOHOLISM: Denied.

DRUG ADDICTION: Denied.

CIVILIAN ARRESTS: Denied.

KENT EGY TEST: IQ 82. MA 11. Borderline intelligence.

PRESENT ILLNESS: Patient saw his father die in October, 1944 after an operation for cancer of the lung. He said that he had not been the same since. After he arrived in England his behaviour attracted the attention of his commanding officer. The patient often seemed frightened, would walk away and appear depressed, strolled through mine fields, had nightmares, saw fire balls and snipers creeping up to him. He talked in his sleep, awakening in terror, and smoked countless cigarets the rest of the night. He heard voices, particularly that of his wife, saying, "Aren't you ashamed?" He heard music and bells ringing. He often cried. He was admitted with a diagnosis of dementia praecox.

The preliminary interview revealed that he had once come upon the body of a dead soldier, a combat casualty, lying in a crater, with only his head exposed and half of it had been blown away by the force of the explosion. The patient also indicated that he always had the feeling that he was being watched or followed by someone, but when he turned around no one was there. He also saw faces which were nebulous or like shadows. "I look at a can on the stove and it turns into a face laughing

at me. It has fangs like a cat, and only one eye." He was so afraid of this ghost that he refused to go to bed the first evening that he was in the hospital, asking to remain up with the attendants.

PSYCHODRAMA: The first psychodramatic scene was an attempt to give substance to the nebulous shadows which were watching and following the patient. An auxiliary ego, a physician, followed him as he walked about the room. At every step the patient turned around to catch a better glimpse of this shadow. Each time this occurred, the "shadow" jumped away quickly. The patient was very much shaken by these realistic episodes. He was taught to turn around and face the man who was following him, to challenge him, and to touch him.

Another scene' was reproduced in which the patient recreated the episode in which he came upon the dead soldier. The assistant, another physician, was placed on the floor in the position of the dead soldier, the patient making certain that all details were scrupulously observed. He seemed very frightened and upset when faced with the body, which, with only one eye open, had the likeness of the "ghosts" he used to see. After much hesitation and resistance he was finally able to comply with commands to handle the body.

We also improvised scenes in which the ghost (the auxiliary ego) jumped at the patient from corners and he had to fight and wrestle with him. To let the patient gain confidence in himself, we let him be the victor in these sham fights.

In order to make him lose his fear of bodies which he was afraid of finding almost anywhere, we placed him in the role of an undertaker (as in case *A*) and he had to pretend he was embalming a body. At first the patient was so afraid of the body that he hid behind a cabinet to avoid looking at it. He gradually lost his fears and even developed some bravado as an imaginary undertaker.

PROGRESS: Improved.

DISPOSITION: The patient was evacuated to a general hospital.

CASE C

ORGANIZATION: Infantry.

PLACE OF BIRTH: Farm in Tennessee.

AGE: 26.

FAMILY HISTORY: Father died of tuberculosis when patient was 17.

HOME LIFE: Normal.

CIVILIAN OCCUPATION: Farmer.

DATE OF INDUCTION: May 25, 1943.

ARMY LIFE: He took a three months' army course to learn to read and write. Rifleman, in E. T. O. one year. In combat three months in France, Belgium and Germany. Received Purple Heart for wounds of left hand.

COURT MARTIAL: None.

MARITAL HISTORY: Married, but has no children.

SOCIAL DISEASES: Denied.

ALCOHOLISM: Denied.

DRUG ADDICTION: Denied.

CIVILIAN ARRESTS: Denied.

KENT EGY TEST: IQ 82. MA 11. Borderline intelligence.

PRESENT ILLNESS: "A buddy and I were in a foxhole in the Huertgen forest without food or water for three days and nights, taking an awful beating from German artillery and small arms fire. When I went back alone on the fourth day for K rations, the Germans counter-attacked. Some were coming from the foxhole where my buddy and I had been dug in 100 yards in front of the rest of the company. We never did see him again. While we were in the foxhole my buddy was always telling me about his girl friend back home, whom he loved very much and whom he planned to marry when he got home again. We would also say many prayers day and night hoping God would have mercy on us so we could get home again. But I suppose he was killed in that counter-attack and will never see his girl again." The patient appeared anxious and tense. He complained that his heart was beating "like a sledgehammer" when he lay down, also about nausea and vomiting after each meal. He showed a marked tremor of his fingers and hyperhydrosis. He stated that he often had nightmares and would wake up bathed in cold sweat.

PSYCHODRAMA: The episode in the foxhole was reenacted. One of the wardboys acted as his buddy and they talked, crouched and prayed as they had done in the real situation. The patient acted very realistically, and seemed to obtain great relief from the process.

DIAGNOSIS: Psychoneurosis, anxiety type.

PROGRESS: Much improved.

DISPOSITION: The patient was evacuated to a general hospital as he seemed to be in need of more rest and unfit for further combat duty.

CASE D

BRANCH OF SERVICE: Quartermaster corps.

PLACE OF BIRTH: Farm in Illinois.

AGE: 28.

OCCUPATION OF FATHER: Farmer.

FAMILY HISTORY: Without significance.

HOME LIFE: Normal.

EDUCATION: Finished eighth grade at the age of 16. Repeated third and fourth grades. Took lessons to correct stuttering.

CIVILIAN OCCUPATION: Farmer and factory worker.

DATE OF INDUCTION: December 19, 1943.

ARMY LIFE: Private, infantry. In E. T. O. since November, 1944. In combat for six weeks in Belgium.

COURT MARTIAL: None.

MARITAL HISTORY: Details given later.

SOCIAL DISEASES: Denied.

ALCOHOLISM: Gets drunk occasionally.

DRUG ADDICTION: Denied.

CIVILIAN ARRESTS: Denied.

KENT EGY TEST: IQ 93, MA 13. Dull normal.

PRESENT ILLNESS: He accidentally shot and killed a 12 year old girl during a street fight in a small Belgian town. He carried her for several blocks to the nearest aid station, but she died in his arms. This incident is constantly on his mind. It takes him a long time to fall asleep and he wakes up with nightmares. His stuttering has become worse. His hands tremble and he bites his nails. He stated that he will never be able to face his wife again, although he had previously given the information that he was not married.

PSYCHODRAMA: The scene in which he killed the Belgian girl was reenacted with a nurse as the auxiliary ego. At first he seemed somewhat embarassed about the idea of carrying a nurse in his arms, but adjusted quickly and reenacted the scene very realistically. Tears came into his eyes and he said, "I have a little girl, too."

We then reproduced the highlights of his life. He had married a girl of 16 despite the objections of her parents, who were particularly opposed to him since she was a Catholic and he was Protestant. An annulment was obtained. He did not see his former wife until just before he went overseas, when she told him that she was pregnant and asked him to marry her

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again. However he refused under the pretext that life during wartime was too uncertain. Her child was born while he was overseas. He has written his former wife only twice since he left the States.

We interpreted this case as one of transfer of guilt. The patient's responsibility for the death of the Belgian child became confused in his mind with the death wishes which he subconsciously had against his own unwanted child, and by the feeling of guilt occasioned by refusing to remarry the mother of his child. This was explained to the patient.

DIAGNOSIS: Psychoneurosis, anxiety type.

PROGRESS: Much improved.

DISPOSITION: Returned to his unit.

CASE E

BRANCH OF SERVICE: Infantry.

PLACE OF BIRTH: Small town in Illinois.

AGE: 27.

OCCUPATION OF FATHER: Insurance agent.

FAMILY HISTORY: No neuropsychiatric determinants.

HOME LIFE: Normal.

EDUCATION: Finished two years of high school.

CIVILIAN OCCUPATION: Clerk.

DATE OF INDUCTION: November 6, 1942.

ARMY LIFE: Sergeant in infantry. In E. T. O. nine months. In combat two months in France.

COURT MARTIAL: None.

MARITAL HISTORY: Happily married four years to a woman six years his senior.

SOCIAL DISEASES: Denied.

ALCOHOLISM: Denied.

DRUG ADDICTION: Denied.

CIVILIAN ARRESTS: Denied.

KENT EGY TEST: IQ 100+. MA 14+. Average intelligence.

PRESENT ILLNESS: This patient suffered from a severe depression for two weeks prior to his admission. He cried often and stood about aimlessly for hours at a time. He refused to eat, stating that he had no appetite. His primary difficulty was one of loneliness. He thought about his wife and child constantly. She appeared before him at night and he talked with her before falling asleep. He also saw her in his dreams.

PSYCHODRAMA: We thought it would help the patient to bring his wife back to him, even though it was only in make believe. With the help of a nurse we reenacted some of the events which had occurred since he had met his wife. In the first scene he acted out how he had met her. At the time he was in a hospital with a broken leg and she was his nurse. They acted out how they talked while she was taking care of him, taking his temperature, rubbing his back, etc. In other scenes he talked with her at the night desk after he was better; how he met her at the nurses' home after he was released from the hospital. In one scene he took her to a dance and she wore an evening gown. He said he had never seen anyone more beautiful. Other scenes reviewed his conversations with his wife at various places as on a park bench, in the foyer of the nurses' home, where they talked about plans for the future. During one of these he asked her to marry him. She objected because he was younger, but he overrode her arguments. They acted out many scenes of their daily married life, how they got up in the morning, how they had breakfast, how she met him after work, etc. In one scene she told him she was pregnant. In another scene he walked back and forth nervously in the fathers' room until he learned that their baby had been born. They reenacted some quarrels. For instance, he wanted to go out and his wife did not, saying she had too much work. He reproached her saying she was becoming almost like his mother. Finally we reproduced several scenes portraying his homecoming after the war, with his wife and child meeting him at the railroad station.

Psychodrama, of course, cannot solve a problem which is the necessary result of the vicissitudes of reality. It cannot, for instance, bring this man and wife together if the war keeps them apart, but it can at least give them realization of the wish on the stage of an imaginary world.

DIAGNOSIS: Psychoneurosis, Reactive depression.

PROGRESS AND DISPOSITION: The patient obtained great relief during these sessions. It was the first time we ever saw him smile. He became very much attached to the nurse. He was discharged to duty in a few days.

CASE F

ORGANIZATION: Quartermaster Service Company.
PLACE OF BIRTH: Shreveport, Louisiana.
AGE: 29.
RACE: Negro.

OCCUPATION OF FATHER: Railroad foreman.

FAMILY HISTORY: His father suffered a stroke in 1936 which paralyzed his right side. His mother was crippled by arthritis. His grandmother, who lived in the house with him, was 80 years old and had great difficulty in walking even with a cane.

EDUCATION: Repeated the sixth grade and finished the ninth.

CIVILIAN OCCUPATION: Mechanic in a defense plant.

DATE OF INDUCTION: October 12, 1942.

ARMY LIFE: Private. In the E. T. O. six months.

COURT MARTIAL: Once for having been AWOL.

MARITAL HISTORY: Single.

SOCIAL DISEASES: Gonorrhea in 1939.

ALCOHOLISM: Drinks frequently.

DRUG ADDICTION: Smoked two marijuana cigarets daily but could not get any in Germany.

PRESENT ILLNESS: Patient was admitted with weakness of the right leg which had appeared two weeks prior to admission. He walked with a cane. Physical examination showed no abnormalities other than a slight tremor of the fingers. Laboratory and X-ray findings were normal.

KENT EGY TEST: IQ 73, MA 10, Borderline intelligence.

PSYCHODRAMA: The patient was asked to demonstrate how his father walked. He walked with a cane, dragging his right leg behind him, just like the patient himself had been walking. He also showed how his mother and grandmother walked. After this demonstration it was easy to convince him that his present symptoms were merely an imitation of the characteristic gaits of the various members of his family.

While this patient was in the hospital, another patient happened to be on the same ward who likewise suffered from a hysterical paralysis. Both patients were called into the session together. One was given the role of the doctor and told to sit at the ward officer's desk. The other took the part of the patient. The "doctor" was instructed to tell his "patient" that all necessary examinations had been made and were negative and that his condition must be a matter of the mind. This was thoroughly explained to the patient until he felt that he really understood this psychodramatic mechanism.

Then we gave the "go ahead" for the scene. The nurse introduced the new "patient" to the "doctor" and the patient gave all his actual complaints

about his paralysis. Then the "doctor" explained in his own words, and to the best of his ability, what he had been instructed to say. He was thus forced to give an explanation for symptoms that were really his own. Then the two patients exchanged their roles and repeated the scene. This is a psychodramatic technique which we often used because it is easy to apply.

DIAGNOSIS: Psychoneurosis, conversion hysteria.

PROGRESS AND DISPOSITION: The patient showed marked improvement and rejoined his unit after five days in the hospital.

CASE G

BRANCH OF SERVICE: Ordnance, tank repair.

PLACE OF BIRTH: Bedford, Mass.

AGE: 32.

OCCUPATION OF FATHER: Engineer.

FAMILY HISTORY: No mental disease.

HOME LIFE: Youngest of five children. Parents got along together.

EDUCATION: At the age of five he suffered a skull fracture and a chest injury in an auto accident. He was hospitalized seven months with a draining empyema. He attended a special school where he received individual attention and much rest.

CIVILIAN OCCUPATION: Messenger boy, bus boy.

CIVILIAN ARRESTS: Three times. At the age of 14 he stole a car together with some other boys, but received only a suspended sentence. At 16 he received a 38 months' sentence for breaking open a safe, and served at the Concord Reformatory from the age of 16 to 19, when he was paroled. He broke his parole and went to New York where he worked as a messenger boy and as a bus boy. He was picked up by police on suspicion of murder, released on that charge, but retained for having broken his parole.

MARITAL HISTORY: Married a waitress and had two children. The second child was born while he was in prison. After his return, his wife would have nothing more to do with him. After he was inducted into the army, he visited her on a furlough and then she agreed to a reconciliation.

DATE OF INDUCTION: 1943.

ARMY LIFE: Unsatisfactory. Rehabilitation camp for six months at his own request, to avoid dishonorable discharge. Carpenter, T5.

COURT MARTIAL: In September 1944 he had a ten day furlough and went on a drinking spree because he was "disgusted with everything." He overstayed his furlough 27 days, was court martialed, and spent six

months in the guard house. He escaped but was picked up in four hours. He said it was planned to give him a dishonorable discharge, but that he pleaded to stay in the army. He was sent to a rehabilitation center at Fort Jackson, South Carolina. There he joined his present unit and accompanied it to the E. T. O.

ALCOHOLISM: Patient had been drinking just prior to admission to the hospital and admitted being a heavy drinker.

DRUG ADDICTION: Denied.

KENT EGY TEST: IQ 73. MA 10. Borderline intelligence.

PRESENT ILLNESS: On admission he was suffering from abdominal pain in the right upper quadrant, which was suggestive of biliary colic. He felt well the next day and had no jaundice. X-ray and laboratory findings were normal. The patient was discharged, but was readmitted on the same day "in a semi-stuporous state, and answered questions only by nodding or shaking his head." He had no injuries or bitten tongue; his pupils were moderately dilated and equal. He soon regained consciousness and appeared normal in every way.

PSYCHODRAMA: The following day the soldier's company commander came to inquire about his condition. We asked him about the incidents immediately preceding the patient's seizure, and he agreed to help re-enact the original scene. The captain explained that after the patient had been returned to duty, he came to the company office asking for a different assignment. He was dissatisfied as a carpenter and asked to be placed in the motor section. The captain answered the request in a noncommittal way, which the patient regarded as a refusal. Immediately following the interview, the patient became very pale, began to perspire, fell to the floor, and his hands and feet shook.

An ambulance was called and took him to the hospital. After a few introductory scenes in which the events in the patient's life and the scene in the carpentry shop had been reenacted, the scene in the company commander's office was portrayed. Both the captain and the patient were asked to use exactly the same words that they had used originally and to enlarge on them with what they were thinking. During the acting the patient suddenly became pale, asked to lie down on the couch, perspired, and his arms and legs shook. We were surprised to see that when we told him "The scene is over now" he immediately stopped shaking and arose to talk with us.

The captain said that the psychodramatic attack was a close duplicate of the original.

Very often a psychodramatic attack can be terminated at will merely by exclaiming "Stop!" to the patient. We regard this possibility of acquiring a faculty to reproduce certain states and then to break away from these states at will as the acquisition of valuable control.

DIAGNOSIS: Psychoneurosis, conversion hysteria.

PROGRESS: The patient had no more attacks and we had no further difficulty with him.

DISPOSITION: Returned to duty.

CASE H

BRANCH OF SERVICE: Infantry.

PLACE OF BIRTH: Cleveland, Ohio.

AGE: 25.

FAMILY HISTORY: Both parents highstrung. A brother was rejected from the army for neuropsychiatric reasons.

OCCUPATION OF FATHER: Salesman.

HOME LIFE: Parents quarreled frequently, usually because the father was interested in other women.

EDUCATION: High school graduate. Was a timid child, blushing easily, afraid to recite in class; often became ill before examinations, sometimes developing "convulsions."

CIVILIAN OCCUPATION: Clerk.

DATE OF INDUCTION: February 22, 1943.

ARMY LIFE: Corporal in the infantry. In the E. T. O. 7 months. Had a "nervous breakdown" after four days of combat in France.

COURT MARTIAL: None.

MARITAL HISTORY: Single. Denies ever having had intercourse.

SOCIAL DISEASES: Denied.

ALCOHOLISM: Denied.

DRUG ADDICTION: Denied.

CIVILIAN ARRESTS: Denied.

INTELLIGENCE: No formal psychometric test was done. He seemed above average in intelligence.

PRESENT ILLNESS: Patient developed a "nervous breakdown" after four days of combat in France. He had "shaking spells" lasting about a half hour, three or four times daily for about two weeks. During these attacks he did not lose consciousness and he did not bite his tongue or injure

himself in any way. He regained control of sphincters. The patient was nervous and tense and had a gross tremor of the hands which were cold and moist. He had nightmares of battle-experiences. He said his trouble began when a shell exploded close to him. He was blown out of his foxhole and was unconscious for about a half hour.

PSYCHODRAMA: We acted out scenes from his early life. Up to his fourteenth year he had "shaking spells". He slept in the same room with his mother so that she could watch out over him. When she left the room he developed "convulsions." We also had him relive some scenes in which he became ill before examinations in school. Finally the scene in which he was blown out of his foxhole was reenacted. After he had regained consciousness he had walked for about forty minutes to rejoin his outfit. When he reached his company he developed a series of attacks.

All these scenes followed each other in rapid sequence which accentuated the similarity in their pattern. The subconscious mechanism of his seizures was explained to the patient.

DIAGNOSIS: Psychoneurosis, hysteria.

PROGRESS: No seizures while in the hospital.

DISPOSITION: Evacuated to a general hospital.

CASE I

ORGANIZATION: Quartermaster service company.

PLACE OF BIRTH: Small town in South Carolina.

AGE: 23.

RACE: Negro.

OCCUPATION OF FATHER: Farmer.

FAMILY HISTORY: Negative.

HOME LIFE: Normal.

EDUCATION: Repeated the third grade, finished the fifth grade. Quit school at 15 to work on the farm.

CIVILIAN OCCUPATION: Foundry worker, farm hand, bricklayer.

DATE OF INDUCTION: March 11, 1943.

ARMY LIFE: Private, worked as a bricklayer. In the E. T. O. eight months but never in combat.

COURT MARTIAL: Denied.

MARITAL HISTORY: Single. Denies intercourse or homosexuality.

SOCIAL DISEASES: Denied

ALCOHOLISM: Denied.

DRUG ADDICTION: Denied.

CIVILIAN ARRESTS: Denied.

KENT EGY TEST: IQ 56. MA 8. Moron level.

PRESENT ILLNESS: Patient was sent to the hospital because he refused all social contacts and preferred solitude; stole little articles of no real value; refused to keep himself or his equipment clean and presentable; and he hoarded such worthless items as empty bottles, in his barracks bag.

In our preliminary interview we learned that he had visual and auditory hallucinations of a religious nature.

PSYCHODRAMA: The patient was placed on a couch, and he was told to imagine he was in bed, having one of his usual visions before falling asleep. It was not difficult to induce him to act.

He sat up, rubbed his eyes, looked up with a rapt expression and said, "I see a white figure beside me, there is a star above his head; he wears a white robe; his arms are outstretched. There is blood on his hands." We asked him to demonstrate what this vision looked like. He got up on a chair, stretched out his arms and said, "There is blood on my hands. It is from the nails."

In another scene we tried to reproduce some of the voices which he used to hear. They were of a religious nature, and one would say, "Pray before it is too late." An auxiliary ego repeated the phrase to the patient first in a normal conversational voice. The patient corrected us, saying that the voice really was a whisper. The auxiliary ego reduced the volume of his voice, but the patient was still dissatisfied. On listening to him again, we discovered that his voice had a Southern accent. When the auxiliary ego reproduced this accent, the patient was satisfied.

This case was particularly interesting because of the ease with which we were able to conduct a psychodramatic session with the patient, even though he was a far advanced schizophrenic and his mental age was only eight.

DIAGNOSIS: Dementia praecox, unclassified.

PROGRESS: Unimproved.

DISPOSITION: Evacuated to a general hospital.

CASE J

BRANCH OF SERVICE: Military police.

PLACE OF BIRTH: Chicago, Illinois.

AGE: 23.

OCCUPATION OF FATHER: Storekeeper.

HOME LIFE: Normal.

EDUCATION: Finished high school and was a good student. Never cared much for social activities, spending most of his time reading.

CIVILIAN OCCUPATION: Office worker.

DATE OF INDUCTION: January 11, 1942.

ARMY LIFE: In E. T. O. with the military police four months. Private.

MARITAL HISTORY: Single. Patient states that he never had sexual intercourse.

SOCIAL DISEASES: Denied.

ALCOHOLISM: Denied.

DRUG ADDICTION: Denied.

CIVILIAN ARRESTS: Denied.

KENT EGY TEST: IQ 100 plus, MA 14 plus. Average intelligence.

PRESENT ILLNESS: Patient states that in recent weeks people have been looking at him in a peculiar way, so much so that he is embarrassed to go out, and tries to get assignments in his company area to avoid the staring of strangers. He believes they are making remarks about his changing into a woman. He thinks that his voice, gait, face and entire body are gradually changing. Because he looks feminine, his steel helmet looks out of place on him and he thinks that everyone is making fun of him and saying how funny he looks in a steel helmet.

PSYCHODRAMA: A number of scenes were improvised in which this feeling of reference was acted out. He was forced to walk through the office wearing a steel helmet, in the presence of several people. He walked up and down, as if he were on a street. Everyone pointed at him, making loud remarks, such as, "Doesn't he look funny wearing a steel helmet?" and "He is changing into a woman!" This was kept up for some time. He admitted that this was just how he felt, but he was amused at the same time. We then continued to act out his fears reducing them to absurdity. We improvised several scenes from Thorne Smith's book, *Turnabout*, in which a man turns into a woman and has a baby. The patient had to go to the doctor, played by an auxiliary ego, and explain that he thought he was

pregnant. All this time he was laughing at the absurdity of the whole procedure and of his fears.

Then we started a program of training to give him assurance, to talk with a deep masculine voice and to walk with a vigorous, manly gait.

DIAGNOSIS: Dementia praecox, paranoid type.

PROGRESS: Improved.

DISPOSITION: Evacuated to a general hospital.

AUDIENCE TREATMENT

The Treatment was given in front of other patients, 10-12, suffering from related mental syndromes. The action on the stage was always followed up by analysis and discussion with the members of the audience (audience catharsis). It appears to the author as the most deep reaching and most effective form of group psychotherapy.

CONCLUSION

The psychodrama is a new form of psychotherapy which has been used here for the first time in an army evacuation hospital.

It is a valuable new tool, easy to apply and with unlimited possibilities. Ten cases treated by this technique are presented here. Because of the short stay of the patients in our hospital and because of the impossibility of a follow up in a theater of operations, we do not consider a statistical evaluation of the results of the psychodrama to be justified at the present time.

We hope to continue our work and plan to follow up this paper with others to show how our method proved itself under the different conditions which we shall encounter.

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PSYCHODRAMATIC TECHNIQUES AS A TEACHING DEVICE IN AN ACCELERATED COURSE FOR WORKERS WITH NEUROPSYCHIATRIC PATIENTS

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The Surgeon General's Office of the Army requested the American National Red Cross to supply one psychiatric social worker for every fifty neuropsychiatric casualties in Army·hospitals. The Red Cross was unable to do this because of overall shortages in the field, but offered to heighten its recruitment of psychiatric social workers and to add to its considerable number of workers already on its hospital staffs, a large number of indoctrinated hospital workers,· to work under its experienced psychiatric social work supervisors in Army hospitals. This plan was accepted by the Surgeon General's Office.

It was agreed that these hospital workers would be college graduates with two years of work experience; that they should have the usual orientation course in general Red Cross philosophy, policies and procedures; and that in addition they would receive specific orientation which would enable them to give service to neuropsychiatric patients.

To implement this agreement the American Red Cross, under the auspices of the Staff Development Section, established a course of one month's duration at St. Elizabeths Hospital in Washington, D. C., in April 1945. The staff consists of a Director, a Training Supervisor and two volunteer assistants. Other specialized Red Cross personnel are utilized as indicated. Experienced psychiatrists on the staff at St. Elizabeths Hospital give the lectures and clinics and other psychiatrically trained specialists are available for supplementary lectures and demonstrations.

′ From the beginning care was taken to present the students with a balanced curriculum of theoretical, clinical and practical work. Attention was given to the utilization of rapid training devices such as audio-visual aids, made available by the U. S. Navy. Time was also allotted in the

curriculum for the use of psychodrama as a teaching technique. This paper is about our use of this instrument as a training device.

Each Saturday morning throughout the course the students and their instructors assemble for a three hour period in the Theatre for Psychodrama. They have been prepared for the experience in a one hour lecture in which simple techniques are described. Differentiation is made between the objectives in the use of psychodrama as a treatment process for patients and as a training method for students, preparing to work with patients.

The psychodramatic staff for these sessions consists of a director, who is an experienced psychodramatist and one auxiliary ego, a well trained psychiatric corpsman of the U. S. Navy, whose long familiarity with neuropsychiatric patients makes him able to enact with versatility patients' roles in varying diagnostic categories. In addition, other auxiliary egos are present whose work at the hospital has enabled them to fulfill realistic roles as nurses, doctors, women patients and relatives of patients. In order to give the students an experience in the supervisory relationship, a supervisor from the Red Cross staff is present as an auxiliary ego. After some experimentation, we found *that the students themselves in this training situation could not serve as auxiliaries; that technically skilled, knowledge*able personnel such as we have described was essential.

In our experience the warming up process for students and auxiliary egos is accomplished more easily when the locale and situation is lifted from the hospital and Red Cross setting and placed firmly in some life situation such as an overcrowded seaside summer hotel during a weekend, when there is pressure for rooms and service by the many guests. This device frees the students from self-consciousness to some degree and gets all of them, as well as the auxiliaries, on the stage at one time or another. It also enables the student to create a role, project and conclude it.

Following this there is a noticeable lessening of tension, a loosening up in which there is free discussion, criticism, questions and laughter. Then and only then are we ready to work on the business of training in the art of the interview, which has brought us together. This is a typical situation:

Mrs. Gerard, an auxiliary ego, the wife of a 30 year old Navy man has arrived unexpectedly at the hospital and is greeted by the Red Cross volunteer in the lobby of the Male Receiving Building. The Gray Lady notifies the husband's ward by telephone and finds that he is unwilling to have his wife come up. The volunteer receptionist then calls the appropriate Red Cross supervisor in this emergency.

The supervisor, an auxiliary ego, gives the case to a *new hospital worker,* who after asking her supervisor all the questions she wants, proceeds through the lobby and to the ward for her first interview with the patient who is still pretty sick and a recent arrival at St. Elizabeths.

She greets the ward nurse in her office, introduces herself, asks for and reads the meagre ward notes and then interviews the new patient who as an auxiliary ego carries out his role of frigid politeness with a suggestion of insolence, disclaims need of help and voices surprise at his wife's arrival, suspicion of her infidelity and neglect of his children and reiterates his unwillingness to see her. The hospital worker concludes the interview, the scene is cut.

Three volunteers (hospital worker students) are withdrawn from the audience so that they do not see one another's interviews, and one at a time successively interview the waiting wife in a corner of the lobby. This standard situation gives opportunity for these workers to try out their knowledge of human behavior, of Red Cross function and of specific hospital policies.

The wife's role as auxiliary ego is that of a skinny, earnest, courageous, hard working little woman with two children who is using her vacation time for this visit with her husband, whom she has not seen in two years. As the story unfolds one finds her working for a tailor, Mr. Levine, whose cousin has a day school and is caring for her children. Mr. Levine has helped her buy a sewing machine, has advanced money on her salary for this trip. The wife throughout the interview persists in her desire to see her husband, cannot understand nor accept his unwillingness to see her, and reiterates her theme about her vacation time, the expense and her disappointment. She is a very determined lady. The student carries and concludes the interview with varying degrees of skill.

We are unable within the limitations of this single article to discuss in detail the resolution of this provocative situation by the three workers. One may concentrate on the practical details of making Mrs. Gerard's visit comfortable; another may hastily go in search of a physician in order that he meet Mrs. Gerard's obvious need for explanation and reassurance; another may telephone her supervisor for suggestions or help or may undertake an explanation herself. The audience meanwhile may wonder if there is any basis in reality for Mr. Gerard's feeling about his wife's unfaithfulness and neglect of his children? In discussion these points and many others come up and are examined freely. A transcript of this segment of a session

would be illuminating here; but we are not able to furnish it in this paper, nor can we do more than suggest a few other useful situations used in training sessions. Such as:

1. A twenty-eight year old Army nurse with a depression has not written home. An urgent letter is received by the Field Director at the hospital from the Red Cross Chapter saying that the nurse's mother is acutely upset because she hasn't had a letter in her daughter's handwriting. The student worker goes to the ward to see the patient in question. Later on the stage she dictates a letter to the Chapter. At times this simple situation has led to an interview with the medical officer and the supervisor.

2. A hypomanic patient, who has written his wife of his promotion from Storekeeper Second Class to Lt. Commander and that he is now in love with a nurse, is seen by the hospital worker in an initial interview.

3. The aggressive wife of an officer arrives, demands to see the Superintendent rather than the ward medical officer; says that her husband isn't sick but in one of his moods from which she can easily snatch him; wants him discharged from the hospital and is unwilling to give a history to the worker.

Weeping mothers, inarticulate fathers, fond aunts, understanding but anxious wives are in the familiar galaxy as are psychopaths, psychoneurotics, and the catatonic, who on interview is mute. Harassed nurses, busy doctors, volunteers and colleagues are encountered on the stage in the logical, spontaneous use of resources by the student.

Frankly, the use of this technique in training was first visualized by us merely as an aid to teaching the art of the interview. We believe, however, after three months' experience in its use with these and other students that it provides a flexible and incisive means of teaching in the round.

Particularly does the student feel the necessity for handling herself, keeping her head and managing her emotions in the midst of her new world with its wartime tensions and confusion. The temptations to lean too heavily or not enough; to become over-identified with a patient or relative; to resort to speech making with an exciting new vocabulary, are ever present, as is the opportunity to hurt, to resort to a half-truth, to meet hostility with hostility.

The impact of this spontaneous realistic drama upon the audience "packs" in the vernacular a "wallop" because of its emotional validity. Instinctive use of old but newly heightened skills by the students, natural grace and flair in the field of human behavior is quickly detected and praised

by the audience. Poor handling of the problems; failure to pick up clues; inability to use silences are noted and analyzed by the students.

We still consider ourselves in the experimental stage, but tentative conclusions are that:

1. The use of psychodrama as a teaching device for students who must quickly learn some of the specifics of dealing with exaggerated, heightened interpersonal relationships provides (a) a non-didactic method (b) by which skills are acquired and (c) without damage to a patient and (d) where recording of a private interview does not intervene to confuse the picture.

2. The auxiliary egos used in training must be masters of their own technical fields in contrast to those used in work with patients.

3. The psychodramatic situations used should be graded as to complexity and correlated with the progress of the students' didactic, theoretical and clinical studies.

4. It seems to prepare the student for her practical work with patients on the wards of the hospital and the students themselves often suggest parallel situations which they are anticipating or experiencing.

5. Because psychodrama presents situations in the round which are worked out to conclusion, it gives the student experience in interpersonal relationships which helps her as well as her instructors to assay the degree of "integration" she has achieved at any given point. By this we mean in plain English that in this one month's course the student has to get into her head, among other essentials, the fundamentals of human behavior and its deviations. This new knowledge must be integrated, must become a part of her so that her own interpersonal relations with those she is trying to help flow with natural, warm-hearted wisdom from a person of firmness and integrity. The very nature of psychodramatic work exploits this necessity.

We might add that the accent is definitely on the *use* the student makes of her new learning through the instrument of her own personality.

Its realistic, spontaneous methodology discourages psychiatric jargon.

The students themselves make written evaluations at the end of the total course, in which they criticize and suggest what has and has not been helpful. In the opinion of all students so far psychodrama is the best teaching technique they have ever encountered. They add that at times it makes them acutely uncomfortable since it puts them on the spot, but all are agreed we should continue its use.

SPONTANEITY TRAINING OF THE FEEBLE-MINDED

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The following account describes the application of Moreno's spontaneity training to a group of feeble-minded boys and girls in an institutional milieu. Only preliminary observations are given inasmuch as the experiment was discontinued when the author resigned from the institution. Because the beginnings of the experiments were so instructive and changed the role-capacities of the patients, I am presenting these preliminary observations here so that it might stimulate others (who have experimental material at hand) to continue a phase of social-psychological and sociometric research which has interesting possibilities.

Prior to the inauguration of the administration which gave assent to this experimental program, the Lincoln State School and Colony in Illinois had been operating on the silent assumption that the institution was a form of correctional or penal institution. *Discipline* was the chief concern of most of the personnel. "The patients have to be kept in line or they will take advantage of you."

The reaction to this form of restrictive and repressive frustration was in the form of occasional aggressive acts and attempts at escape, but more frequently the repression of spontaneity on the part of the patients. The institution sponsored stereotyped behavior. If one followed the rules, stayed in line, did not speak to girls, did not react to a drunken attendant's uncouth or obscene language,—in short, if one behaved like an automaton, he was considered a good boy. It can be said that the patients were forced to act like feeble-minded people are supposed to act—stupid, without self-expression, without spontaneity. It was little wonder, then, that when an occasional boy or girl was paroled for outside work, the adjustment was too difficult and the parolee was returned to the School.

The assumption behind the author's attempt at social re-education was simply that feeble-minded people (more correctly, morons) are not obliged to be stupid. The group selected for study was made up of late adolescents and early adults. The youngest was 16, the oldest, 28. Most were in their early twenties. The IQ's ranged from 57 to 84, the mean being 61. Most had been in the institution at least seven years. The size of the group fluctuated: most of the time 8 to 10 girls and 6 to 12 boys were present.

The experiment really began several months before any formal action was taken. The author had earlier adopted an attitude of acceptance toward the patients. That is to say, they were treated as they expected human beings to be treated: with dignity, fairness, and without condescension. These expectations may have come from the radio, the movies, the schools, or their interactions with the outside world prior to entering the institution, but they did *not* come from interactions with most of the politically-appointed personnel.

The attitude of acceptance was implemented by overlooking many concrete acts which would have resulted in disciplinary action, by drinking soft-drinks in the commissary with the boys, by giving them virtual freedom of my apartment, etc. The disparity between the traditional treatment based on out-moded penal theories and the acceptance accorded by the author was soon perceived.

The first problem confronted by the author in the beginning of the experiment centered around the fact that these boys and girls were not accustomed to working or playing together. For many years, the administration seemed to have been chiefly concerned with preventing pregnancies. This was carried to such an extreme that if a boy or girl was discovered talking to a patient of the opposite sex or passing notes, the most severe form of disciplinary action was invoked. Even the weekly dances, which were attended by all the older boys and girls, did not allow mixed dancing. The girls would dance with each other and the boys likewise. (Parenthetically, homosexuality was frequently practiced and severely punished—yet dancing between members of the same sex was supported and encouraged.)

Against this background, the experimenter organized and carried out the initial stages of a program designed to introduce more adequate social responses into their meager repertory of behavior. During the first few meetings, the girls would sit on one side of the room, the boys on the other. Giggling, embarrassment, and other actions disturbed the smooth workings of our program. After the first week, however, the strain of heterosexual contact was overcome and there was a freer interplay of conversation between the boys and girls.

In order to profit from their previous experiences, we began by "having a play." Prior to this time, in the summer of each year a cast was selected for a Christmas play and each character was drilled and drilled into learning lines which were finally intoned in characteristically rigid performances.

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One of the group selected a play from the library. It was a sophisticated Broadway success of several years ago. Because of its length, we decided to assign parts for the first act. However, instead of giving each person a "part" to memorize, the whole play was read by the experimenter—with an interpretation. The next step was for each of the characters to take the role assigned him without a script. The experimenter took the role of a stage director here—indicating to each of the 10 characters who he was, what he was supposed to be doing, why, and how. Each actor was encouraged to use his own words.

By the artifice of "having a play" the group was warmed-up to the task of taking roles in spontaneous fashion. Now the play was discarded and the purpose of the psychodrama explained in simple terms. The subjects were told that in order for them to be ready to accept the responsibilities of the outside world if and when paroled, they would have to be prepared for the adjustments demanded by non-institutional setting. It should be added that these patients were not entirely ignorant of the outside world—only one of the patients had spent his entire 26 years in the institution, the others for the most part had come to the institution during adolescence. In addition, the weekly motion pictures and the radio acquainted them with some of the behavior responses characteristic of the world outside.

At this point, simple situations were outlined and volunteers from the group took roles. The delivery boy, the iceman, the milkman, the maid, the gardener, the grocer's helper, the farm boy, the child nurse, these and other roles were assigned and acted out. The spectators, i.e., members of the group not on the stage, would actively criticize discrepancies between the actions of the actor and the demands of the role. The procedure was a direct contravention of methods usually taken in dealing with mental deficients. Instead of the laborious and dull methods of repetition—depending on the old Thorndikean Law of Exercise—the subject was encouraged to be spontaneous, to act the role in any way he saw fit. In this part of the experiment, the giggling and razzing disappeared entirely.

After four weeks (three mornings a week), one of the girls asked if they could do a family scene. The experimenter approved. She adjourned to the adjacent hall with four other girls and two of the younger boys. After about 10 minutes, they returned and seated themselves around a large table (our only prop). The two boys were seated somewhat apart from the girls —apparently engrossed in an imaginary game of checkers. The girl who

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had suggested the action was the mother, the others were her children. Following is a record of what happened:

FLORENCE (the mother): Jane go to the store and get some milk and a loaf o' bread. It's near supper time and Paw'll be comin' home.

JANE: Aw! Send somebody else! I'm tired.

FLORENCE: Cripes sake! You ain't done a thing all day and you're tired. Get goin!

JANE: Why aincha askin' one o' them lazy boys. They ain't doin' nothin' but playin' checkers.

FLORENCE: You get goin' or I'll bat your ears in. (Exit Jane, grumbling)

SUSIE: I wonder how Paw will be when he gits home. If he hits me agin I'm goin' to run away.

MARY: I betcha he ain't comin' home tonight. I betcha he's gettin' drunk somewhere.

FLORENCE: Don't talk about your Paw thataway.

JIM: If he lays his hands on me again, I'll clip him one.

FLORENCE: Shut up! or I'll clip you. (To Mary) Go set the table. I'll mash the potatoes. (Business of setting table and mashing potatoes.)

The dialog is here interrupted to interpose an observation. The psychodrama does not easily lend itself to literary description. This situation is not an uncommon one among the families of committed feeble-minded patients. Broken homes due to alcoholism frequently bring dependent children into the juvenile or local courts, and commitment seems the easiest way of handling a vexing social problem. These girls acted the roles so convincingly that visitors at this session questioned that it was not rehearsed many times. What they were doing was reliving a scene which in its fundamentals was a part of their own experience.

To continue the psychodramatic record:

Jane returns to the stage. She places a quart of milk on the table. (She had actually gone to the neighboring building and procured a quart of milk.) When are we gonna eat?

FLORENCE: Soon as Paw gits here.

(At this point, Fred, one of the older patients in the audience, spontaneously rose from his seat and walked up to the action. Although he was not in the preparation at all, the actors were so warmed up that his intrusion did not interfere with the smooth functioning of the psychodrama.)

FRED (to Florence): Hiya Maw, Supper ready?

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FLORENCE (Without a moment's hesitation): It's about time. Where ya been? Ya ain't been drinking, have yah?

FRED: Nope. (Then to two boys who are still playing checkers). Come on boys, time to eat.

(Here a moment's hesitation. Then Fred speaks again.)

FRED: Maw, I got sumpin' for yuh. (He takes a piece of crumpled newspaper from his pocket.)

FLORENCE: Five dollars! What'll we buy with it?

The action continued with an animated interchange of ideas as to what five dollars would buy.

This is reproduced here to demonstrate that even feeble-minded patients who have been forced into stereotyped roles can be warmed up to role-taking. Naturally, the variety of roles will be less than with people of normal intelligence. Of special significance is the fact that Fred, a *non-participant* in the preparation for the action, saw an opportunity to play the role of the father and took it. Furthermore, the other players interacted with him in spontaneous fashion without any overt disturbance.

This anecdote is one of many which took place during a two-months period. Although no attempts were made to introduce controls or to refine the experimental procedures, the author is convinced that such methods will reduce our institutional populations.

The foregoing observations suggest this hypothesis: morons can be stimulated to react intelligently to social situations through the use of psychodramatic and spontaneity training methods.

Testing and verification of this hypothesis would help solve not only the social and economic aspects of feeble-mindedness, but would contribute to a better theoretical formulation as to the social psychological nature of intelligent and non-intelligent behavior.

PATIENTS AS THERAPEUTIC AGENTS IN A MENTAL HOSPITAL

GERHARD SCHAUER, M.D.

⅄ Everyday experience teaches us that people function better in one group, worse in another.

Everyday observation in mental institutions teaches that the same thing is true among mental patients. We can safely say that one group in certain situations has a beneficial effect upon one individual's well being and functioning, whereas another group does not. And we can call this beneficial effect, which the individual derives from his inter-action with other group members "therapeutic," because he is "helped" or "served" by the group in attaining greater well-being, personality development and greater freedom of expression of his particular kind of spontaneity than he would in a different social environment.

Interesting studies of this effect have been made by Moreno and co-workers, in placing patients into the social group and social situation in which they are able to function most effectively, i.e. where inter-action between individual and group in a social situation is of maximum therapeutic efficiency. The application of this principle has been called assignment therapy.

Just as in medical therapy a system of therapeutic units has been worked out, by which drugs like digitalis or insulin can be given to a patient with exact knowledge of their effects, a method would be desirable, by means of which the beneficial or detrimental effects taking place between the members of a group with regard to some social situation could be similarly evaluated.

During a recent stay at a small psychiatric sanatorium* an attempt was made to evaluate the beneficial and detrimental inter-actions taking place in the hospital community by means of sociometric testing. A number of sample situations were selected for which the individual group members, patients as well as staff, were interviewed with regard to greatest and least preference for each other. The total participation was computed and each group member was scored according to several criteria. The test results reflected the social hierarchy in the community. The majority of choices went to a few individuals who by the nature of their occupation, were in key

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*Beacon Hill, Beacon, N. Y.

positions in the community. The fact that they actually received the greater part of choices indicates that their personalities qualified them to assume key positions (nurses, assistants). It was further found that these key individuals extended their preferences with regard to the sample situations largely to the medical director, who, besides being chosen directly, became the recipient of many indirect choices. "The amount of direct influence the leader of the group exerted, was minimal, compared with the amount of influence he exerted actually, mostly via indirect channels." (Aristo-tele).

In evaluating the contribution made by the patients toward the equilibrium and welfare of the group, sociometric testing showed this to be approximately 20% of the total "therapeutic energy," determined by this method. By observation it was found that several of the patients assumed therapeutic functions for each other. The figures obtained suggested that the contribution of the patients to the adjustment and welfare of the group to the hospital situation is not negligible, if compared to the contribution of the staff, especially as the latter has been so far regarded as the sole carrier of therapeutic functions. In larger institutions, with greater numerical discrepancy between staff and patients, the contribution of the patients towards the stability of the hospital community should be much greater. However this would have to be submitted to actual sociometric testing, with its accompanying activizing effects upon the community.

DRAMA THERAPY

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The drama therapy at Fitzsimons General Hospital is conducted under the supervision and direction of the Chief of the Neuropsychiatric Service, who works in close contact with the "drama team."* This team consists of a dramatic director who is an enlisted man having an M.A. degree in dramatics from Kansas State College and Washington University, an assistant who is a civilian nurse with considerable experience on a military psychiatric ward and as an amateur actress, and a stenographer. Each of these individuals has received considerable orientation in clinical psychiatry and semantics, and are now taking the courses in psychodrama (1) given by Dr. Moreno and his assistants at Denver University.

At present, drama therapy is being used at Fitzsimons only with closed ward patients having both psychotic and psychoneurotic diagnoses. The patients are selected and the treatment is prescribed by the psychiatrist.

Various techniques are employed depending upon the nature of the case and the purpose desired.

(1) One type of approach makes use of ventilation of fixed emotionalized attitudes that are sources of tension and conflict, followed by an attempt at reconstruction and re-orientation.

In this method, the patient, or group of patients, is presented a situation or topic for discussion about which certain rigid emotionalized attitudes are held. With the aid of the director and a supporting character, the patient is led to verbalize these attitudes by a process of "ad libbing." This material is recorded by the stenographer and transcribed. It is then edited by deleting irrelevant statements without changing the wording. After this is completed, each patient reads and acts out his own script. At this point an electrical transcription is made of the performance. At a later date, each patient listens individually to his recording and is asked to discuss the ideas and emotions he previously expressed. This is also recorded. It is followed by a psychotherapeutic interview with the psychiatrist.

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*In this phase of our treatment program, I am indebted to T/5 Orvis Grout, Med. Det., drama director; Miss Lee Zanon, R.N., assistant; and Miss Jessie Greensley, stenographer, who compose the "drama team."

(2) In another technique, the patient, with the aid of supporting characters, re-enacts various emotionally traumatic episodes encountered during his military and combat experience. He is required to re-enact these experiences many times until, through a process of desensitization, they no longer serve as *foci* of anxiety.

The material in this approach may be furnished by the psychiatrist from his study of the patient with or without pentothal sodium, or obtained from the patient during the development of the drama situation. In either case, the procedure is one of catharsis and desensitization.

(3) In a third technique, the patient is given certain emotional situations to act out on the stage. The situation may be an immediate one facing the patient, or any one of several likely to be experienced upon return to civilian life; such as, returning to wife and home, answering inquisitive friends concerning experiences and reasons for discharge, finding a job, or going back to school, etc.

In securing the material for this type of drama situation, the patient is given a setting or situation suggested by his particular problem. He is then required to project himself into it and to behave or react as if he were encountering a similar situation in "real life." This extemporaneous material is recorded by the stenographer and transcribed. With the aid of this script material a second drama session is held in which the patient is "coached" to make proper and adequate adjustment reactions.

This technique actually represents a variation of the second one described above. In that approach, the patient becomes desensitized to past emotionally traumatic episodes; whereas in this one, he becomes desensitized to anxiety-laden anticipated situations. By this process of "learning by doing," anxiety of the future is lessened and confidence is regained.

(4) In a fourth approach, utilization is made of "opposites." Here, an aggressive patient is given a submissive role or *vice versa*; or an enlisted man with considerable hostility towards officers is given an officer's role. In the former situation, the patient acquires experience in inhibiting or extroverting, as the case may be; in the latter, he gains insight and understanding and experiences an amelioration of his hostility. This technique is also followed by a psychotherapeutic interview with the psychiatrist when indicated.

In addition to these uses of the drama as an aid in therapy, it is also being used in teaching student nurses how to handle various psychiatric

situations and problems. For example, the student is presented with a patient who refuses to eat (played by a student) and is required to show by acting out, the proper method of dealing with the problem. In another drama situation, the student is confronted with a visiting relative who asks many questions and expresses doubts and fears concerning the patient's illness. The student is expected to act out the proper handling of the problem. These and many other problem situations in psychiatric nursing are enacted by the students with the view that they learn best by doing.

There are many ways in which the stage can be used effectively for therapeutic purposes. For us, the methods described are simple, effective, and serve a useful purpose.

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SOCIODRAMA

A SOCIODRAMATIC AUDIENCE TEST

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INTRODUCTION

In an earlier paper the author pointed out the value of psychodramatic methods for educating and adjusting the draftee to the role of the soldier and alleviating strains of the hangovers of roles in civilian life. It is clear that such training need not be limited to training for the military, but that in reverse, it may be employed in the readjustment to civilian life. While considering the problems of the returnee, it is pertinent to consider equally the responsibility of those to whom the men return. Much is heard concerning the rehabilitation of our fighting men but little is done about the rehabilitation of the families they left behind. Their attitudes towards occupation, fraternization, re-education of former enemies, relations with friendly nations, relations to minority groups at home, employment for veterans, to mention but a few larger categories, are of primary importance in a sociodramatic program of rehabilitation.

In psychodrama we deal with collective as well as private ideologies; the method dealing with the former has become known as "Sociodrama." It is, of course, not possible to separate *the* soldier from *a* soldier, *the* son from *a* son, they are the product of influences of both a private and collective nature. However, there are certain aspects of their performance which are shared by all other soldiers, all other sons. It is these collective aspects of their roles with which we deal in sociodrama (7).

We propose to bring forth in this paper some of the highlights of audience tests made at the Psychodramatic Institute in New York and Beacon with the relatives and friends of fighting men.

CATEGORIES OF STANDARD SITUATIONS

Three main categories of standard situations have been used in the past at the Institute. Moreno has called them the *Three Situation Set:* Intimate or Family Situation, Work Situation and Community Situation. The set proved useful in analyzing the range of representative roles in which

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subjects function. In a recent session Moreno (9) suggested that in dealing with audiences requiring a more refined analysis of role-interaction, the Three Situation Set may be replaced by a *Seven Situation Set:* Government vs. Citizen, Husband vs. Wife, Parent vs. Child, Sibling vs. Sibling, Employer vs. Employee, Stranger vs. Native. According to Confucius there were five basic human relations: Ruler vs. Subject, Husband vs. Wife, Father vs. Mother, Older Brother vs. Younger Brother, and finally Father vs. Son. The two situations added above did not have any significance in the Chinese culture of Confucius' time—those of the Employer vs. the Employee, and the Stranger vs. the Native.

We will illustrate here how the polarity, Role of the Stranger vs. Role of the Native, can be used in the testing of audiences. In this category may fall many groups, for instance ethnic minorities, enemies, refugees, but also in certain situations, our own veterans. Following the pattern of role analysis elsewhere described (11), we used as the subjects of our investigation people who were facing an adjustment problem which they wished to have treated on the stage. Since it is impossible to test every member of the audience representatives are picked, but such representatives who themselves have a similar problem, to remove the elements of fiction which might otherwise so easily creep into sociodramatic sessions. The problem should always be as concrete as possible, the Negro-White conflict, the G.I. vs. the Civilian, etc., using certain typical situations in which this conflict is most clearly demonstrated (1). It has become a rule at the Institute to place on the stage three representative samples and to let the audience react to them, as soon as the scenes are ended. A greater number of subjects may be used, but experience has shown that in general, three are sufficient to allow a cross-section analysis of the role structure of the audience. Three subjects chosen at random show, if taken by surprise, widely contrasting enactments of the same situation. Some of the more popular audience tests are, for example: Three automobile drivers are given the following instructions—You are driving along a parkway. Although the speed limit is 45 miles per hour, you are in a hurry to get somewhere. You may be driving too fast. Go ahead, warm yourself up to driving a car. An auxiliary ego in the role of a State Trooper is told to stop them and to give each subject a ticket for speeding. (Subjects are called out one at a time, they do not see anyone else's performance until they have taken their turn.) The results have varied from abject subordination on the part of the testee, to bribery of and lastly, assault on the State Trooper. One subject threatened to drive

fast enough to kill himself upon being stopped. Further inquiry disclosed that he did not know how to drive a car, and this type was entitled "fantasy driver." He behaved in an irrational, fantastic fashion, out of proportion to the stimulus offered, much as a mental patient might. Experiments with many fantasy drivers have shown weird reactions, though not all of them as extreme as the above mentioned. An audience vote was taken after three versions had been demonstrated and an analysis of votes made. Another test dealt with the return of three discharged veterans to their home town. They were asked how they planned to return, at what time of day or night, and who would be at home to meet them. I recall that in one case a subject returned at night, alone, taking his family by surprise. His wife was at home, tinkering with an electric iron that had broken down. She was happy to see him and he immediately made himself useful by repairing her iron. Another returned to his mother and took it easy for at least a month before attempting to look for a job. A third did not go home, but settled down in a big city. He had learnt a new trade in the army and wanted to apply it in civilian life rather than to return to his father's farm, or else to go back to school and to take advantage of the government's program in making up for his lack of education. Again, an audience analysis was made and the votes recorded. Yet another test was made in which the subjects were all women. The auxiliary ego used in this scene was a serviceman still in uniform. The subjects were "warmed up" to the following theme: You are driving along a lonely highway at night. You are alone and anxious to get home as it is a dark night and quite late. Go ahead. The auxiliary ego (in the soldier's uniform) was instructed to go up to the subject with the request to be given a ride to a point up the road, stating that it was an emergency. On the average, out of a series of three subjects given this test, two did not stop each time to pick up the soldier although he had campaign ribbons and sundry decorations. Reasons given for not doing so were: "Well, I was alone and it was at night." "I'm ashamed to admit it, but I'd be afraid to." "I would if it were day time." "One reads such awful stories in the newspapers, I would only do it if a man were with me." "It was dark and I couldn't tell whether he was a clean-cut man or not." Among the subjects who stopped to give the soldier a life one was a "fantasy driver"; the second said that she was too old to worry about whether it was safe or not, a third stated that her husband was in the army too, and she'd like to think someone would do the same for him if need be. Again audience reactions were taken, and the testees who did

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find reasons for giving the soldier a ride did not find as large adherence as those who refused to pick him up.

The following tests presented here were given to nine unselected audiences, using three subjects in all cases. The aim of our investigation was to determine whether this method, used on many audiences, would enable us to find what constitutes: (a) a "typical" audience, (b) a "marginal" audience and (c) a sociopathic or "sociotic" audience. A typical audience (from the point of view of role configuration) was defined as drawing a majority of votes in at least 75 per cent of all potential audiences in the United States, at a time when the test was given. A marginal audience was defined as drawing a minority of votes in 25 per cent or less, of all potential audiences in this country. A sociotic audience, the membership of which are not necessarily mental patients, would show pathological role structure; according to Moreno's definition* the single individuals may be normal, their *interaction* is abnormal.

THE TEST SITUATION

Instructions to the Subjects

Our subjects were mothers of a son in the services whom they were shortly expecting home. An auxiliary ego represented the son. The situation was: Your son has returned from Germany about a week ago. Before he left for the army he was in love with a girl from your home town. They planned to be married when he returned from overseas. The girl has come to you today and complained that his affections for her have cooled, she fears that she has lost him. You are deeply disturbed and want to find out what has happened to your boy, and why this change has come over him. Act the way you would toward your own son under similar circumstances.

Instructions to the Auxiliary Ego (not heard by the subjects)

Your function is that of the tester. Your performance has to be the *same* in the case of each subject. Everyone of these mothers will probably produce a varying emotional response to the situation. You, however, must present as much as possible the same stimulus in all cases. You are our instrument of measurement (2, 3, 4, 6). Remember that you have recently come home and are discharged from the army. You were engaged to an American

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*See *Who Shall Survive?*, p. 192.

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girl before leaving for Germany and you planned to marry her. But, during your stay in Germany you met and fell in love with a German girl whose father had been a member of the Nazi party. You and this girl are devoted to each other and have promised to marry. You have not mentioned it to your family or former fiancee, but you are going to tell your mother now.

Reactions of the Subjects

We are merely indicating some crucial moments in the presentation of three of the typical mothers. *Our first mother* reacted as follows, after the boy had stated his plans:

Mother: But are you sure you love this girl? Does not the fact that her father was a Nazi make you suspicious of her? Have you given the matter earnest thought?

Son: I have thought it over very carefully, mother. I don't care what her father was, I love her. She is just as sweet and lovable as any other girl and we want to get married. I want to get her over here.

Mother: Well, I don't want to stand in the way of your happiness and I'm sure no one else in the family will either, if you sincerely believe you're doing the right thing. But how can you be sure? Perhaps she is using you just to get out of that country!

Son: Mother, that is not true. She loved me when I was over there, even before we thought of getting married.

Mother: I can't say I'm not disappointed. After all, we've known Ellen since she was a little girl. The families have known one another so long, and you were engaged to her. Who's going to tell her?

Son: I'll have to. I'm sure that Ellen will understand, she wouldn't want me to pretend to her that everything is the same as before.

Mother: It's not going to be easy for any of us, but we'll do our best. Of course, you're going to live in a home of your own.

Son: Don't worry. Everything will work out alright.

Mother Number Two presented a more receptive picture.

Mother: The important thing is that you love her and that she really loves you.

Son: Oh, but we do love each other. Why pretend?

Mother: I feel sorry for Ellen. You'd better tell her. She was very unhappy about you. I can see now why she would be. It's going to be hard for her, living so close by.

Son: I'll tell her mother, I'm sure she'll understand. You can't fool your own heart.

Mother: But what do you plan to do about your girl?

Son: I'm going to have her come here. Then we'll get married.

Mother: Well, we shall be very glad to have her. Of course, she'll stay with us.

Son: Thanks, Mom, I knew you'd understand.

Mother: It will be lonely for her at times, so far away from her own people. I know that anyone whom you pick for a wife must be a very fine person, no matter what her political connections are. As long as she makes you happy we will all be fond of her, too. We'll try to make her feel at home, you can be sure of that.

Mother Number Three was of a different mind.

Mother: But how *can* you fall in love with a girl like that? I don't understand! Her father and his gang have put thousands of our boys to death, and murdered other innocent people. What were you fighting this war for, anyway? How can you call yourself an American and look a girl like that in the face?

Son: But mother, I love her. What difference does it make what her father did, or anyone else, for that matter? She is just like any other sweet, lovable girl and I know she loves me. Don't you think that's important?

Mother: Ellen loves you too. Are you thinking about her? How do you suppose she'll feel about this?

Son: I'm sure Ellen will understand. Love is more important than what anyone thinks.

Mother: Are you planning to go to Germany and live there?

Son: No, I had thought to bring the girl here, so we could be married at home.

Mother: Bring that girl here? Into my house? Never! I will never stand for that, and neither will Dad and your brother. Why, think of it, your brother is going into the army himself this year, how do you think he'd feel? And Ellen living here in town, too. You must be out of your mind. I don't understand you at all. You're not like our boy anymore. The war certainly changed you!

The analysis following the demonstration of the three solutions showed significant differences in the nine audiences. The questions to which audio-egos responded were: With whom of the three mothers did you identify yourself? Why did you pick her? Is it because *you are* in the same situation? Do *you know someone* who is in the same situation? Is any one of the

other mothers *closer* to your own situation? If so, why did you not choose the one whose problem resembles yours? How did you feel about the son? Do you think he acted the way a son should have acted towards his mother? Do you think a soldier should do what he did? Would you behave that way if you were in his predicament? How do you feel about his action towards the American girl? If you have such a problem, would seeing these three different versions of behavior enable you to find a solution of your own?

This test was given soon after the war with Germany had come to an end. Table 1 was constructed on the basis of answers to the question: with whom of the three mothers did you identify yourself? It bears out our estimate of what constitutes a "typical" and a "marginal" audience. All but Audience No. II and Audience No. VII gave an overwhelmingly superior

TABLE 1
AUDIENCE ANALYSIS—MOTHER ROLE
(100 persons in each case)

Audience	I	II	III	IV	V	VI	VII	VIII
Mother 1	11%	19%	15%	31%	9%	13%	23%	16%
Mother 2	29%	53%	36%	22%	15%	14%	49%	38%
Mother 3	55%	25%	47%	41%	67%	65%	24%	40%
No Vote	5%	3%	2%	16%	9%	8%	4%	6%
	100%	100%	100%	100%	100%	100%	100%	100%

vote to the rejecting mother, No. 3. Audience participation was whole-hearted, as can be seen from the relatively few neutral votes. The largest number of neutral votes occurred in Audience IV, 16 per cent, and it is of interest that this is the only case where Mother No. 1 had a larger following in these audiences than Mother No. 2. Mother No. 1, as we recall, was the one whose reaction came closer to that of No. 3; she was not altogether unwilling to accept the German girl, although she foresaw difficulties. Further questioning of this audience revealed that the large number of neutral votes was due to the hesitance voters experienced in casting their vote either totally for or totally against, and this may be why Mother No. 1 came second for the first time. In Audience No. VI Mother No. 1 is on almost the same level as Mother No. 2, but Mother No. 3 is still far ahead of both. Our marginal audiences, No. II and VII showed a preference for Mother No. 2, the loving type who considered her son's happiness first and his judgment unfailing. A further study of Table 1 shows that Audience VII rated Mother No. 1 and 3 almost equally, with only a difference of 1 per cent in favor of the latter. This audience gave

a lower score to Mother No. 3 than all the others, nowhere else did this mother get a minimum of 24 per cent, the next lowest being in our other marginal audience, No. II, where she received only 25 per cent. It is noteworthy that the contest between the two extremes, Mother No. 2 and Mother No. 3 is far more explicit, pointing to how high emotions ran, either pro or con. Audience No. VIII, for example, finds Mother No. 2 only 2 per cent short of Mother No. 3.

A re-test of this kind at the present time might show a shift in favor of Mother No. 2, now that mothers are no longer bombarded by wartime propaganda. However, at that point in time the representative of that great national, clinical collective, Mother No. 3, was greatly favored. It is of interest that both Ellen and the German girl were symbols. Neither were actually known to the mothers but Ellen was automatically preferred and the German girl rejected, although nothing was brought forward concerning her as an individual which might have placed her in an unfavorable light. It was merely the collective aspect, that of the Nazi affiliation, which was sufficient for her to be pushed aside. Not one of the mothers who rejected her considered the possibility that she might have been in discord with her father's views, or perhaps even of so-called non-aryan origin. Such findings would indicate that if Mother No. 3 were still at the top of the list at present, the longer the occupation of Germany and Japan lasts, the greater may be the resistance built up by the families of men in the occupation armies to their foreign brides, and the more hostility they would find upon their return home.

TABLE 2

AUDIENCE ANALYSIS—MOTHER ROLE

(Audience IX—25 persons)

Mother 1	16%
Mother 2	16%
Mother 3	20%
No Vote	48%
	100%

In the case of the ninth audience a vote structure resulted which does not resemble that of either the typical or the marginal audiences, see Table 2. Nearly half of the group did not vote. This audience showed some preference for Mother No. 3. The close contest between the three mothers was due to the fact that the problem did not appear as a test to the audience, but as a true case. The reason given for the slight preference for Mother No. 3 was that she was more outspoken. However, the striking thing about this

audience is the large percentage of "No Vote." Upon interview it was found that a number of the spectators belonging to this group felt that "it was not a test, but a real problem." They were convinced that the boy on the stage was not an auxiliary ego, but that he presented his own personal case. It was further revealed that many had the idea that the presumably Nazi girl was in the audience and that they suspected several girls "from the way they acted." The spectators had many other ideas of a delusionary and illogical nature. An audience of mental patients might show such a structure. However, these were *not* mental patients or disturbed individuals, they were just highly sensitive to the procedure on the stage and to each other (5, 10, 12). We have termed this type of audience a "sociotic" audience and it is felt that, although it may not occur as frequently as the other two, it represents a large faction of the population which must be dealt with. Such an audience may, f.i. be apprehensive to certain films. Careful audience diagnosis is therefore a perequisite to audience psychotherapy (8).

We plan a re-test of the *same* audiences for report at a future date. It seems to us that this sociodramatic approach would lend itself to a more intimate public opinion polling of representative samples than do present methods. Expressing an opinion in these sessions is not left unrelated to the voter's own life; his vote is motivated and taken only after he is warmed up to the problem of which he is given a chance to see several alternative solutions. The sociodramatic stimulus in an audience test can be either extemporaneous sociodrama, a rehearsed sociodrama or an especially constructed diagnostic film. Motion pictures have been used at the Institute for audience diagnosis and for therapeutic guidance. In the form of the rehearsed sociodrama and the film, the audience to be tested remains entirely spontaneous, only the process on the stage or screen is prepared and conserved. Many agencies are using these "conserved" forms of sociodrama today. In time to come it may well be that for use with large numbers of groups the moving picture will supplement the rehearsed sociodrama in the flesh because of its greater ease in reproduction.

Although apparently merely a testing procedure, this sociodramatic approach has cathartic as well as diagnostic value. However, for guidance purposes, in the case of both the rehearsed and film sociodrama, a "director of the audience" must be present to use findings on the spot and turn these findings into therapeutic channels. At times he may have to stop the film in the middle, and/or to employ it as a step in the warming up of the audience to a self-presentation. According to Moreno, we cannot hope to

use only frozen editions of psycho- and sociodrama. They should not be regarded as tools which can stand alone, but as adjuncts to actual psycho- and sociodramatic sessions.

CONCLUSIONS

The sociodramatic audience test is presented as a diagnostic measure for audiences.

To date two sets of standard life situations have been used at the Psychodramatic Institute, the Three Situation Set and the Seven Situation Set. The polarity, Role of the Stranger vs. Role of the Native, was used to test our audiences.

Moreno's audience test is used, exposing nine audiences to the same sociodramatic stimulus. Analysis of the vote is made and categories of subjects are established. Audiences are subjected to the same theme and the same auxiliary egos.

It was found that audiences could be classified as typical, marginal and sociotic, according to the role configurations found within them.

The meaning of symbolic roles was discussed and their bearing on individual behavior.

Sociodramatic methods, spontaneous, rehearsed and in films, could be used as measures of public opinion. It is foreshadowed that sociodramatic films may eventually be used on a large scale. In sociodrama and group psychodrama it is the audience which is the subject, and therefore con- served forms should be supplementary to sessions in the flesh. An audience director should always be present, especially in the frozen editions of psycho- and sociodrama, in order to guide the findings on the spot into therapeutic channels.

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ROLE-PLAYING AS A METHOD OF TRAINING FOREMEN

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The use of psychodramatic or role-playing methods in the training of leaders is relatively new.[1,2] Even more recently these same methods have been applied to the training of foremen with such promising results that the time seems ripe to describe the technique by presenting some concrete case material and to delineate some of the problems and possibilities.

The following material is selected from stenographic records of the first and last sessions of a training course conducted by the author as part of a larger research program at the Harwood Manufacturing Corporation, a sewing plant employing 650 workers. The training group consisted of the department head (a man), the supervisors (as the foremen—all women—are called), and irregular attendants (such as the department trainer) in a department of 100 employees. The Personal Manager, the Plant Manager the Engineer and the President visited some of the training sessions.

Though limited to the area of interpersonal problems the conception of supervisory training was unusually broad, for it attempted to improve performance not only by teaching social skills to the supervisors, but also by changing any other factors affecting their performance—e.g. their position in the factory, their relations to higher management, company policies, and so forth.

After a brief introduction to the course with no mention of role-playing, the first step of the first meeting was to get a rough diagnosis of felt training needs by asking the trainees to write down their *most frequent, most difficult,* and *most distasteful* personnel problems. Since the management had recently required the supervisors to prevent excessive talking among the operators, this was the most pressing problem:

TRAINER: Well, they all have one thing in common, *talking.* That seems to be our chief problem. Shall we start in on that?

ALL: Yes! (Very definite and strong decision.)

[1]French, J. R. P. Jr., Retraining an autocratic leader, *J. of Abnorm. & Soc. Psychol.,* Vol 39, 1944.

[2]Lippitt, R., The psychodrama in leadership training, *Sociometry,* Vol. VI, No. 3, 1943.

MARY: That's much our biggest problem.

TRAINER: O.K. Since things seem different here than out on the floor, we will try to make it seem more realistic here and try to feel as if we were out there. Bill, you come up here and run this machine. (Pulls out a desk and puts two chairs behind it.)

BILL: (Walking to the desk). I'm being a guinea pig.

TRAINER: Evelyn, you sit here and be the girl beside him. (She gets up and sits beside Bill, giggling a little.) Now Mary will go out of the room and be the supervisor. Mary, you can go into that office there, then I'll tell you when to come in. These girls will be talking, and you are to be your self and tell them to stop and show us just how you do it. (All are giggling a little and acting self-conscious and shy.) What I want you to do is not just act it out in a funny way, but I want you to *be* the operator or the supervisor and do just what you would do under those circumstances. Mary, you be yourself and stop these two girls from talking. Bill and Evelyn, you *are* girls and you're talking. O.K. Go ahead. Start talking you two.

BILL: Well, Evelyn, if we've got to talk about something, we might as well talk about this idea. What do you think of it, Evelyn?

TRAINER: No. that's not it. Girls won't talk about that.

BILL: Well, they talk about what they did last night and I'm not going to do that! (Giggles again.)

TRAINER: Come on, be girls. Go ahead and talk about what you did last night.

EVELYN: Well, did you go to the movies last night?

BILL: No, I stayed home and peeled onions!

TRAINER: O.K. Come in and stop them Mary. (Mary enters rather self-consciously and leans on the desk laughing.)

MARY: Come on you girls stop talking. Now Bill (Getting completely out of character,) you gotta give me a *good* answer!

TRAINER: Oh Mary, now you've spoiled it. You're supposed to be your-self out there on the floor. You wouldn't say that to two operators. O.K. Let's try it again. Mary, go back into the other room. (She goes out, and Bill and Evelyn start talking again.)

EVELYN: Are you going to the movies tonight? How about going with me?

BILL: No, I can't.

EVELYN: Oh, *please.* You can go! (With real spontaneity.)

BILL: Nope, gotta can liver tonight.

TRAINER: All right Mary.

MARY: (Speaking loudly in a scolding tone of voice.) You girls are making too much noise. (Slipped out of her role for a moment and giggled.)

BILL: We're just talking.

MARY: You're not supposed to talk.

EVELYN: Why we've got to talk. You can't live without talking.

MARY: You can't talk. It bothers others. Now quit talking. Mr. Smith (the Plant Manager) says there's too much boisterous talking.

EVELYN: If I can't talk I'm going to kick to somebody.

MARY: O.K. Suppose you go tell Mr. Smith down in the office.

BILL: If you're gonna talk that way, I quit! (Trainer stops the role-playing.)

TRAINER: Good! Is that real, is that what usually happens? Bill, did it seem real to you? (Bill assents.) Mary, did it seem realistic to you? Is that the way the girls talk to you on the floor? (Mary assents.) Well what about your giggling when you first spoke to the girls—you don't usually do that do you?

MARY: No.

TRAINER: Bill, you sure were talking hateful. Do the girls really talk back to you the way you did to Mary?

BILL: They sure do! But I think Mary did it wrong. She should have done it different. She should have asked us our reasons for talking and she wasn't clear enough about why we shouldn't talk. She should have explained more.

TRAINER: (Feeling that the criticism, though correct, will arouse ego-defenses.) Maybe so, but first let's go back to the question of whether this situation is real. I noticed that one girl supported the other. Do they usually support each other against you? Do you usually have to talk to two people at once?

MARY: (Apparently ignoring trainer's question and going back to Bill's criticism of her technique.) When I talked with two of them the other day, I did explain more. I told them Mr. Smith said there was too much talking, that it was too loud and boisterous, that it bothered other people and slowed down the work and took their attention away from their work.

TRAINER: Evelyn, you did some pretty tough talking. How did you feel about it.

EVELYN: I would have felt better if she had spoken to me more quietly and personally.

TRAINER: When there are two of you involved, doesn't she usually have to talk to both of you?

EVELYN: I guess so, but she shouldn't have done it so loud. It made me mad.

TRAINER: What was it that made you so mad? And when you said you would go to Mr. Smith, did you mean it?

EVELYN: Sure I did. I was good and mad.

In the ensuing discussion, the supervisors felt that appealing to the authority of the plant manager annoyed the girls and weakened the position of the supervisor. "You can't let them think you're afraid of them or that you're job-scared!"

TRAINER: Well, we did a pretty good job on that one. Let's try it again with Bill as supervisor and see if we get some more ideas and see how differently he handles it from Mary. (Bill goes out of the room. The two girls sit at the desk as operators. There is no silliness or giggling this time. They get right to work and fit into their parts, seeming to enjoy it and getting the idea very well.)

EVELYN: Are you going to the show tonight Mary?

MARY: I don't think so, went last night.

EVELYN: Wasn't that a good show? Gee I liked it. He was so handsome and she was so good! (Evelyn seems to be very much involved. Continues talking enthusiastically about the show, her voice raised and quite excited.)

BILL: (Comes in quietly and walks up to desk, leaning on it with both hands. Waits a moment. Both girls stop speaking and look up at him.) Girls, you all are talking too much.

MARY: Why Bill we weren't saying much.

EVELYN: We're doing our work all right aren't we?

MARY: Yeah, we're making our units aren't we?

BILL: (Hesitating for just a moment.) Maybe you two girls are making your units, but they're others who aren't. Your talking bothers them.

MARY: We don't care about them. Let them look out for themselves. We're doing all right.

EVELYN: Yeah. We do all right. And we gotta talk.

BILL: We can't get the production out if you bother others and talk so
     boisterous.

MARY: I don't care about production. I'm just working until I can get
     a release anyhow. If you don't like the way we act, go ahead and give
     us our release.

EVELYN: Yes, give us our release. We don't care. But we gotta talk.
     That's what tongues are made for.

MARY: Yeah. Tongues are fastened in the back and loose in the middle
     just so people can talk! So let's get our release and quit. Come on
     Evelyn. (Bill is flabbergasted and seems stuck. Trainer ends the role-
     playing situation.)

TRAINER: O.K. Good! Bill you certainly got a couple of hateful girls
     there. Are they often like that?

MARY: I used some of the same words a girl used on me the other day.
     She went on explaining about how the tongue was made for the longest
     time.

TRAINER: I was rather surprised when both of you asked for your release.
     Would a girl ask for one as easily as that?

MARY: Sure. One told me the other day really that she wanted a release
     and that she was just acting up so she could get it. What do you say
     when they do that?

TRAINER: I see that is the way they have been doing it all along. This situ-
     ation really seemed real then. Now how do you feel, Mary, when Bill
     was talking to you?

MARY: Mad.

TRAINER: Mad at what?

MARY: At getting a scolding I guess. Maybe I felt guilty too. (Some dis-
     cussion of a related incident on the floor follows.)

TRAINER: I know about that. But let's get back to this situation and the
     other one. We've got two ways of handling the problem and let's make
     a comparison. What was the difference between the way Bill handled
     it and the way Mary did?

EVELYN: I still think that if they had spoken more privately about it,
     we wouldn't have felt so mad.

TRAINER: I thought Bill did it pretty quietly.

EVELYN: Yes, but he spoke to us both at once. I would have felt better
     if he had called me up and spoken to me alone.

TRAINER: I had the opinion that Bill did it more privately and quietly.

EVELYN: Yes, she just rushed in and scolded.

TRAINER: Which did it more firmly? Evelyn, you were a girl in each. Which do you think?

EVELYN: I don't know.

TRAINER: Which was the more friendly?

EVELYN: Bill, I guess.

TRAINER: Which gave the most satisfactory explanation?

EVELYN: Bill, I believe.

TRAINER: (Boosting Mary's ego.) Bill of course had the second try. I know Mary would have done it very differently another time. The first time it is hard to do and hard to really be yourself. Now the time's up. Do you want to stop or do you want to go on for a bit?

MARY: Let's go on. This is a tough problem and we've got to meet it tomorrow and every other day, so let's find out how to do it.

EVELYN: Yes, let's get it settled.

BILL: O.K. Only don't let's stay after 5:30.

The discussion continued until the supervisors concluded that the girls resented being asked not to talk because they did not understand that the supervisors were carrying out a new company policy which applied to all employees. So we decided to have group meetings of each production line in order to explain the new policy on talking and the reasons for it.

The sixth meeting was devoted to the topic of how to talk to operators about increasing their production. A brief discussion revealed that it was standard procedure for every supervisor to show each of her girls the daily production record and to try to get the inefficient operators to increase their production.

TRAINER: Now that much is cleared up then, and I want to see how you do it. So let's act it out as we did before.

BILL: Give me a cigarette first.

TRAINER: Sure, pass them around. I've got plenty today.

EVELYN: Don't ask me to do it.[1]

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[1] The spontaneity of the role-playing in this meeting was less than at intervening meetings, probably because two superiors (the Personnel Manager and the Plant Engineer) were present as visitors.

TRAINER: (Getting up to arrange a table as a machine.) All right. Mary, who are the tough girls in your line. Who is a girl who can do more, you are sure, and yet just isn't improving and hasn't for some time?

MARY: Well, Dixie is one, and that little new girl, the one who is making pockets, Bill.

TRAINER: All right, let's take the little new girl. What's her name?

MARY: Oakie Shapely.

TRAINER: Do you know her Anne? (A supervisor attending for the first time.)

ANNE: Yes, I know her.

TRAINER: Do you know her, Evelyn?

EVELYN: I've never talked to her, though I know what she looks like.

TRAINER: Well, Anne, you come up here and be Oakie.

ANNE: Oh I'll just watch, Jack.

TRAINER: Oh you can come up and just be talked to. (She gets up, giggling a little and sits at the desk.) Now remember you are Oakie Shapely. Now let's find out more about you. What's your rating?

MARY: She rated 37 yesterday. Wasn't it, Bill?

BILL: Yes, 37. She's come up a dozen a day the last few days.

TRAINER: How does she feel about her work? Does she like her job?

MARY: She likes her job and tries hard.

TRAINER: That's good. She'll be an easy case then. That's a good one to start on. (Moving a chair.) Here let's give Mary plenty of room. (Much laughter from all.)

MARY: Oh talkin' doesn't take that much room Jack. (She comes over to the table with a sheet of paper which the trainer has given her to use as a daily production record.) Oakie, you made 37 units yesterday. You are doing nicely. I'm proud of you. You said you were going to make 37 and you did.

ANNE: Well, Mary, I'll try to make 38 or 39 now.

MARY: I hope you will and I'm sure you will.

ANNE: Well I'll try.

MARY: I know you will try and I think you can make it all right.

TRAINER: (Breaking off the role-playing session.) OK. That's fine. That was an easy case, where the girl already wants to cooperate. Now I know a really tough one, Evelyn. Dottie Sholley.

BILL: Yeah. She's a tough one.

TRAINER: Have you been talking with Dottie lately, Evelyn.

EVELYN: I talked with Selma yesterday and Dottie today.

TRAINER: O.K. you show us how you talked to Dottie. Dottie has been working on the job for two or three months hasn't she?

EVELYN: No, about six weeks. First we had her on another job, but she's so little and the bundles were too big for her to carry. So we switched her to pockets.

TRAINER: Oh. What's her rating now.

EVELYN: 37. She made 41 once.

TRAINER: And how does she feel about her production?

EVELYN: Oh she wants to do it, but she wants you to help. Today she started to pick up two bundles. I met her at the table. I told her she should only take one, and she said she wasted too much time getting bundles and that when she worked in Bristol they had bundle girls who brought the bundles to them. I needed the bundle for another girl, so I told her to take one and that I'd bring her another. She said she wanted me to be her bundle girl. So I was her supply girl all day.

TRAINER: O.K. This is tomorrow and you find out she only made 30 units.

EVELYN: Oh Jack! After I carried her work to her all day, she only makes 30!

TRAINER: I told you this was going to be a tough one!

EVELYN: That's too tough!

TRAINER: Well, it sometimes happens that way.

EVELYN: I don't see what I could do if it happened that way.

TRAINER: Well, take a try at it.

EVELYN: (Getting up reluctantly and going over to Anne at the desk.) Well, Dottie, you only made thirty units yesterday. Did you have any special trouble? After I brought you all your work too.

ANNE: I didn't feel good.

EVELYN: Did you have any machine trouble or anything?

ANNE: Yes, I did.

EVELYN: Well, why didn't you put your little red light on?

ANNE: I don't know. I guess I forgot. And the thread breaks all the time.

EVELYN: Well, you should tell me about those things so I can help you. You'll do that after this, won't you? And you'll try to do better too, won't you?

ANNE: Yes, but I don't know if I can. It's hard to do.

TRAINER: That's fine. Now let's talk about these two cases.

.   The discussion continues with suggestions of using check studies and additional training. In the discussion of "making excuses", the Personnel Manager thinks the supervisor should find out whether the girl has any personal problems. Because the trainer knows that Evelyn has caused resentment by prying into the personal affairs of her girls and because he wants to criticize the argumentative technique without criticising her personally, he sets up a special situation.

TRAINER: Let's see how Mr. Jones (the Personnel Manager) would tackle this problem. I'll be the girl, the same girl Anne was last time. (Sits at the "machine.")

MR. JONES: Well, it just seems to me this way. There's lots of things that might be holding the girl back. Possibly she got a letter from her boy friend that had bad news in it, or something like that.

TRAINER: Well, let's try it out and see how it works.

MR. JONES: (Getting up from his chair.) What did you say your name was?

TRAINER: Dottie Sholley.

MR. JONES: (Now acting the role of supervisor.) I have some bad news for you here, Dottie. It seems you have fallen down a little in your units. What seems to be the trouble?

TRAINER: Well, I didn't feel so good.

MR. JONES: But when you asked me to be your supply girl you seemed to be feeling well enough.

TRAINER: Well, I got some machine trouble and that slows me up. And these old threads break all the time. You can't do much when that happens.

MR. JONES: (Pause for a moment.) Did you go to the show last night?

TRAINER: No.

MR. JONES: Anyone in your family sick?

TRAINER: No.

MR. JONES: Did you have a date last night?

TRAINER: No! I'm married!

MR. JONES: And you say you haven't been feeling well?

TRAINER: No I wasn't feeling well, but that was just yesterday.

MR. JONES: You don't feel sick most of the time?

TRAINER: No that was just a little stomach trouble. There's nothing wrong with me!

MR. JONES: (Laughing) You're sure bucking me. I give up!

BILL: If you let them get into an argument with you you'll never get out. They answer and answer and answer.

TRAINER: Thanks. I certainly was being a tough one! ! Now let me give you my reactions. When you came up saying you had bad news I felt nervous. I didn't like that, so I was sort of on the defensive. I was thinking, now what am I going to say? I thought of something, and then while I thought of that I thought of something else to have ready for the next question. Then he asked me about my family and that scared me. I thought maybe something was wrong. Then he asked me if I had had a date, and I was married. That made me so mad I nearly slapped him. And when he asked me again about my health I tried to assure him that I was in good health because I was afraid maybe he would fire me if he thought I was sick all the time. Now, this is the toughest kind of case you will get. A girl who doesn't do what she can do and you just can't find out why. Now would you like me to try the skunk oil method?

BILL: Yeah, I think so.

TRAINER: O.K. You be the girl, Bill.

BILL: Sure, I'll answer your questions.

TRAINER: You try to be the same girl that Anne was and that I was. Be as tough as you want to.

BILL: O.K. (Sits down at the table.)

TRAINER: (Approaching Bill with the sheet in his hands.) Hello Dottie. Here's the unit sheet for today. Let's see, where's your name? (Turning the sheets with Bill's help.) I guess it's over on another page. What have you been doing?

BILL: Well, I made 30.

TRAINER: How does that compare with what you've been doing? Is that good, for you, or not so good?

BILL: Well, I have done better.

TRAINER: How long have you been on the job?

BILL: Oh about eight or ten weeks, but they change me around so much.

TRAINER: How long have you been on this job?

BILL: About six weeks.

TRAINER: Well, it usually takes a girl three or four months to make 60. You say you have done better?

BILL: Yes.

TRAINER: Have any trouble yesterday?

BILL: Yes, the thread breaks all the time. And I had such little bundles. I had to get more all the time.

TRAINER: Oh, I'm sorry. I told you yesterday I was going to bring you a lot.

BILL: But they're too little. You run through them in no time.

TRAINER: What you want to do is not worry about your progress one day or another day. How much do you suppose you will make a week from today? Maybe you'll get some small bundles and maybe your machine will give you trouble· but counting that in, what do you suppose you'll make in a week?

BILL: I don't know. I might make 40 or 45.

TRAINER: You think you could make 40 or 45! Why I've known girls who have taken three or four weeks to get up there from 30! What's the best you have made?

BILL: I think it's 48.

TRAINER: Well, maybe you could then. How'd you like to try and make 40 by next Friday?

BILL: You mean just do 40 by next Friday?

TRAINER: Yes, that gives you a good chance in spite of machine trouble and those things that you can't help that come up. Do you think you could do it?

BILL: I believe so.

TRAINER: Now I don't think you can do it if you have troubles that aren't your fault. Now on the matter of thread breaks, sometimes that's the way you hold your cloth and sometimes the trouble is with the machine. When you get trouble like that, we can have the mechanic in or we can get the trainer over to see what's wrong. You want to have perfect working conditions. I'll come over Friday to see if you've made it, and I'll come around every other day, too, to see if I can help in some way. (End of role playing.)

MR. JONES: Fine!

TRAINER: I don't think I did that very well, but I was trying to use a different technique. Now what's the difference?

MR. JONES: Well, you weren't on the defensive all the time.

TRAINER: You mean Bill didn't put me on the defensive?

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BILL: What he means is when you were the operator you answered him
        back. And I could answer all your questions to me this time, but there
        never was any blame on me.

The discussion continued for fifteen minutes on the details of how to
avoid arguments, putting a person on the defensive, the use of production
goals, why the trainer tried to make a goal out of the *lower* of the two esti-
mates given by the girl, etc.

DISCUSSION

Compared with other methods of training foremen to handle interper-
sonal relations (e.g. reading, lectures, conferences and discussions, etc.) the
role-playing method has a number of distinctive characteristics. It is a dra-
matic play-like activity on an *irreal* plane. Paradoxically, it is also very
concrete and *realistic*—probably as close as possible to actual job perform-
ance. In a number of ways it is extremely *flexible*: the trainer can play a
variety of roles himself; he can assign the trainee any type of role; and he
can place the trainee in a wide range of situations. Finally, it stimulates
participation, involvement, and identification in such a way as to bring out
the deeper *emotional* aspects of interpersonal relations.

These four broad descriptive characteristics seem to result in a number
of more specific possibilities and advantages of the role-playing method:
1.   It helps in solving the vexing problem of the *transfer of training*
by providing a concrete and realistic setting wherein the supervisor prac-
tices what she must actually do in her real job. Each of the situations in
the above protocol is either a typical problem for these supervisors or a very
specific problem of one supervisor with a particular employee. Often the
problems are inaccessible to on-the-job training, either because they occur
infrequently or because they must be handled privately. In any case, role-
playing provides an excellent bridge from *talking about* interpersonal rela-
tions to *actually handling* them.
2.   As the trainee performs, the trainer can coach her, *immediately* cor-
recting the errors and reinforcing the desired behavior; whereas on-the-job
training usually necessitates a longer gap between performance on the one
hand and reward and punishment on the other hand. In a life situation,
this gap makes it impossible to give the supervisor a knowledge of the
results of her behavior except in a very vague way. But in role-playing this
can be done in a detailed and concrete way: for example, in showing the kind

of behavior which produces "making excuses" the trainer could set up a situation to produce this behavior (cf. p. 11 ff.) and then get "introspections" from the "employee."

3.   Role-playing provides an excellent means for the essential first step in successful training, namely the *diagnosis of training needs*. Verbal techniques—like writing down their most frequent, most difficult, and most distasteful problems—do not reveal the training needs of which they are unaware nor do they accurately describe the felt needs. In this case they merely pointed out the known fact that the supervisors were unable to handle the specific discipline problem of talking. But the subsequent role-playing (cf. p. 4 ff.) revealed in the first minute that the supervisor was antagonizing the employees by talking down to them and scolding them like children; that in her insecurity she was appealing to the authority of the Plant Manager and thus undermining her own authority; that she did not consider the reasons why the employees talked; that she did not adequately explain the reasons for the regulations against talking; and that she argued with the employees. Not only does role-playing provide such opportunities for the observation of training needs, but it even facilitates the use of test situations to determine how well a trainee can actually handle various problems.

4.   *Sensitivity training* is an important part of the training process, for supervisors (even the women) are often insensitive to both the reactions of their workers and their own methods of leadership. In the above case on making excuses, the supervisors quickly became sensitized to the reactions of the employees through the process of identification in playing the role of the worker and through listening to the introspections of others in that role. They gained insight into all the training needs mentioned above and into more subtle problems like the relation between guilt feelings and defensiveness. Likewise they have an unusually good opportunity to become sensitive to different methods and styles of leadership through seeing, in rapid succession and under the guidance of the trainer, numerous leaders handling the same problem. In the sixth training session (cf. p. 8 ff.) there were three examples of different leaders handling the identical problem with different methods.

5.   Role-playing is effective partly because it increases the trainer's control of the social environment in a number of ways. (a) The trainee can be assigned roles for specific therapeutic and training purposes. In the above protocol the supervisors and department head played the roles of both

supervisor and worker; furthermore· they progressed from generalized roles (cf. p. 4) to playing the roles of particular individuals (cf. p. 8). (b) For purposes of demonstration the trainer can play the roles of supervisor and worker; yet he can easily shift to the role of coach, observer, or discussion leader. (c) The trainer can use all types of situations—past, present, or future. It may be a problem of discipline or production; but whatever the area, the trainer can vary the type and difficulty of the situation to meet the present training needs. For example, Evelyn felt strongly that one should speak separately to two girls who are talking (cf. pp. 4, 6), so the trainer set up a situation (in the second session) where she had only three minutes to stop two girls from talking before she had to leave the department. When the situation was played, it revealed that both girls just *had* to talk after she left in order to find out what the supervisor had said to the other one. (d) In setting up a situation the trainer can control the degree of reality-irreality, not only as a whole, but differentially for the different parts; e.g. an extremely defensive supervisor (cf. p. 11) was criticized indirectly by replaying the identical realistic situation, yet using a different person in the role of supervisor in order to circumvent her ego-defenses. (e) Role-playing helps the trainer to build an active and creative group because the technique requires the participation of all group members in a way which ties in with their own important problems. Passive listening without participation is not nearly as much of a problem as it is in a conference or discussion group. Often the dramatic aspect adds to the fun and enjoyment and improves the group's morale (cf. p. 6). (f) Role-playing also tends to extend the trainer's control of the social environment beyond the confines of the training session and into the areas of the supervisor's position in the organizational structure, her relations with other members of management, and even company policies. Thus the training can attack problems which are ordinarily outside the realm of training. At the beginning of the course, for example, one supervisor was refusing to accept the authority of the newly created department head; but as their interpersonal relations were improved within the training sessions, the actual structure and functioning of the department changed out on the sewing floor. Because it inevitably reveals problem situations, facilitates the diagnosis of these situations, and frequently suggests solutions, we find that the role-playing naturally resulted in such actions as group meetings to inform the employees of the new policy on talking, getting the management to fulfill a broken promise to some employees

by increasing their piece-work rate, clarifying the duties and responsibilities of all supervisors in the plant, etc. Of course role-playing is only one tool in achieving these broader results of training, and the greater the number of levels in the institutional hierarchy which are included in the group, the more effective it seems to be.

6.   One of the most difficult problems of all training in the area of inter-personal relations is the frequent rigidity and resistance to change which stems from ego-defenses and other motivational factors or simply from ancient habits. Role-playing is an effective method of combatting these resistances, for its irreal character means that the supervisor is not playing for keeps and there is less ego threat in trying out new patterns of behavior. This freedom from fear on the part of the individual supervisor is paralleled by a freedom and fluidity of the training group which makes possible and suc-cessful a new method of leadership which could not even be tried in the real situation. In the above protocols there is considerable ego-defensiveness, yet it is definitely less than that encountered on the job beforehand and even after the course. Probably it could have been further reduced by making the role-playing less realistic.

7.   Both in changing the supervisory techniques of individuals and in im-proving interpersonal relations within the institutional hierarchy, role-play-ing seems to provide a useful *catharsis*. In the first attempt (cf. p. 2 ff.) every trainee showed the typical forms of resistance to playing a role: giggling and self-consciousness, talking about the role instead of playing it, dropping out of character, and not wanting to play a role. But surprisingly quickly they warmed up to the point where they were playing a role with real feeling and some enjoyment. At this point it became evident that the role-playing provided a release for feelings and emotions. Mary, for exam-ple (cf. p. 5) was very evidently relishing her role and playing it with gusto when she told the supervisor that "tongues are fastened in the back and loose in the middle just so people can talk!" When it came out that she had been on the receiving end of this same remark from one of her own girls, it seemed probable that she released a tension which would other-wise have disturbed her relation with this girl. Such catharsis seemed to be even more effective in the relations of the supervisors to their superiors. Probably something of this kind was involved in their frequently expressed desire to have the trainer play the role of supervisor.

8.   There are some reasons why role-playing seems particularly adapted

to the training of foremen. In the first place a foreman must often play a role—and a very difficult one at that—in his real job. In some respects he is a worker while in others he is a member of management, and he is always at the fulcrum of conflict by virtue of his position in the industrial hierarchy. Thus the problems of position and status are unusually acute for him, and role-playing seems particularly adapted to handling such interpersonal problems.

In the second place, foremen want concrete and specific help with their daily problems; they have little patience with abstractions and generalized advice. But in their interpersonal problems it is usually impossible to give this concrete type of help except through role-playing because the problems are inaccessible to on-the-job training.

Finally, the competitiveness of industry put a premium on efficiency; and role-playing is efficient because it can accomplish with a whole group at the same time what would otherwise have to be done individually.

ROLE TESTS AND ROLE DIAGRAMS OF CHILDREN

A Psychodramatic Approach to an Anthropological Problem

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INTRODUCTION

In the course of psychodramatic research, it has been frequently postulated that the role is the most important single factor determining the cultural atmosphere of personality. "The tangible aspects of what is known as 'ego' are the roles in which he operates. . . . We consider roles and relationships between roles the most significant development within any specific culture."*

In the drama, the taking and playing of roles are natural reference points. One does not refer to the private Mr. *X,* who plays the role, but to the role which he plays. The attitudes which he has as Mr. *A* do not matter to begin with. What matters are the attitudes in the role. The attitudes which may be characteristic of an actor as a private person, for instance, John Barrymore, are not relevant here; what is relevant are the attitudes which are supposed to be characteristic of a specific role, Hamlet.

The recent studies of attitudes, such as dominance and submission, etc., do not seem to the authors as productive as the working with "roles" as points of reference. It appears to be a shortcut and a methodical advantage as compared with personality or ego as points of reference. The latter are less concrete and wrapped up in metapsychological mysteriousness.

The authors have tried to examine this assumption by setting up a specific program for role research. Since Binet introduced a test to measure intelligence, frequent efforts have been made to construct a test measuring "personality". Perhaps no test to study personality shows so much promise as a "role" test because of the close interaction of the role process with personality formation, on the one hand, and the cultural context of situations, on the other hand. As, according to premise, the role range of an individual stands for the inflection of a given culture into the personalities belonging to it, the "role test" would measure the role behavior of an

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*Moreno, J. L., "Psychodramatic Treatment of Marriage Problems," *Sociometry,* Vol. 3, No. 1, 1940. The authors, consciously, do not try to define what "culture" is. They prefer to let a definition grow out of experiments like these.

individual, and thereby reveal the *degree* of differentiation a specific culture has attained within an individual, and his interpretation of this culture. Just as the intelligence test measures the mental age of an individual, the role test can measure his *cultural age.* The ratio between the chronological age and the cultural age of an individual may then be called his cultural quotient.

<div align="center">PROCEDURE</div>

The project has been set up in two places: one in a small town—project A, and the other in an underprivileged section of New York City—project B.

In *project A,* a jury of five persons in the community where the children live had been formed to determine the characteristic roles of the community, presumably the roles they will have to perceive or act in, in the future. A total of 55 roles were quoted by the jury as follows:

> mother-father, brother-sister, doctor, nurse, teacher, gardener, maid, policeman, mailman, minister, taxicab driver, electrician, carpenter, fireman, telephone operator, painter, cook, president, mayor, citizen, post office clerk, railroad ticket agent, expressman, librarian, barber, beautician, waiter, butler, undertaker, pilot, soldier, sailor, general, automobile mechanic, factory worker, factory foreman, bus driver, postmaster, coal man, radio entertainer, ice cream salesman, architect (building contractor), lawyer, engineer, conductor, storekeeper, judge, banker, plumber, butcher, baker, druggist, milkman, psychiatrist, gas station man.

The following fifteen roles have received their highest preference scores:

> mother-father, brother-sister, policeman, teacher, doctor, taxicab driver, mailman, minister, plumber, banker, lawyer, railroad engineer, conductor, storekeeper, judge.

The set of roles used for the test, it was agreed, may vary from one community to another, and more drastically, from one culture to another. The selection of the roles to be tested is of crucial importance, because if the roles of which the set consists are only incidental to the life of that particular community, no true picture of the child's role behavior and potentialities can be attained. Therefore, the point was to select such roles which are truly representative and operative in the community in which the testees live.

In differential anthropological studies, comparing two cultures, the task would be to determine identical role patterns (such as soldier or priest)

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and the *un*-identical role patterns, that is, such roles in one culture for which there are no correspondents in the other (such as scientist and airplane pilot, for which there is no parallel in pre-historic cultures).

In *project B,* a parallel procedure was established. A jury of five, living in the neighborhood from which the children were selected, was chosen. They, too, have each been asked to select the roles which they would consider characteristic for the community in which they live. No limit was set to the number of roles they could list. They listed 105 roles, nearly twice as much as the jury in the small town (project A). They proceeded, then, to select from their list the fifteen roles most pertinent, in their judgment, for the children to act in and to understand. Their final list was finally compared with the one listed above for project A, and a discrepancy was found between the two lists of roles. Ten roles were the same; the following five were not listed: mailman, plumber, minister (but replaced by priest), banker and railroad engineer.

In project A,* the role test, as applied to individual subjects, was divided into two procedures: (a) role enactment, and (b) role perception. The division was made for analytic reasons, although actually, enactment and perception cannot be fully separated.

The test was given to a large number of children. The test results with six children are here presented. (See Table 1 for details.)

Description of Test

A child was asked to enact one after the other of the fifteen selected roles. In order to reduce self-consciousness to a minimum and aid in his warming up to their enactment, the entire procedure was presented to the child as a game. An older child, coached as an auxiliary ego, served as an audience to guess what each role was, after the subject had enacted it. In order that the subject might not feel that attention was being focussed especially upon him, or if he refused to enact the roles, the auxiliary ego enacted a role, *not* included in the selected fifteen, and the subject guessed what role it was. This interaction usually served as a starter for the subject.

The instructions were: (1) *Show* us what he (a policeman, a teacher, etc.) does. (2) If the subject hesitated after a time, or indicated that he had finished the enactment of the role, he was asked: "What *else* does he (the policeman, the teacher, etc.) do?" (3) If the subject was unable to warm up at all to the enactment of a role, he was asked: "If you cannot

*The results of the tests given in project B will be presented in a subsequent paper.

act, *tell* us what he (policeman, teacher, etc.) does." (4) If the subject described the role correctly, he was urged again to try and enact it.

Once the roles were established which the subject was *unable* to enact, an effort was made to determine whether they were able to *recognize* them. They were enacted, then, by the same adult in a standardized dramatic form, with each role phase occurring in a standardized sequence. Every role was divided into a series of meaningful acts of which it consisted. One child might *recognize* a role after seeing one or another characteristic act of it, for instance, an attitude of the body or a gesture. Another child might have to see two or more act phases in order to recognize a role. But even among the roles which a child was able to *enact*, there might be a varying degree of inadequacy, for instance, a child might enact only one or two phases of a role, and deem it sufficient, either because she did not warm up to more (although she might have been *aware* of more), or because her awareness was limited.

RESULTS

The following shows samples of results from the role tests given to two of the children, who live in the same community, are neighbors and friends since they were two and a half years old, are of the same chronological age (6 yrs.) and above the average in intelligence (118 and 140). (Every role enactment is broken up (1, 2, 3, etc.) into its significant phases.)

	RITA	KAY
Policeman	1. Stands still, waving hands as if directing traffic, says, "All right, go this way." Motions with hands.	1. "What am I supposed to do?" (Child auxiliary ego enacts another role; still does not warm up.)
	2. Changes position thus indicating being in another part of town, and says (as if to someone): "You're arrested because you stole something."	Perception: When the tester enacts the role in all its phases, she recognizes the role.
	3. "If you shoot, I'll kill you."	
Teacher	1. Directing conversation as if to a group, in condescending and serious attitude: "Now children, you may paint and color, or do whatever you wish."	1. "I don't know."
		Perception: Recognized role after one phase of enactment.
	2. "Later, we go out and play."	
Street-cleaner	1. "Now we have to clean the streets."	1. "I clean streets." To tester: "I don't know what to do."
	2. "Here is the brush so the road can be clear." Makes motions of sweeping as though using the long-handled brush of the street-cleaner.	

	RITA	KAY
Storekeeper	1. "Could I have some bananas? How much are they?" (taking the role of customer). 2. Moves around as if coming behind counter, opposite customer: "$25." 3. Coming back to position of customer: "All right, I'll take some." 4. Offers money to storekeeper.	1. "I don't know." Perception: After first phase of enactment, recognizes role.
Judge	1. "Get out of here. What did you do to that lady?" 2. "Write her name down. She is a naughty lady." 3. Aside to adult: "He's in the court house."	1. "I don't know." Perception: Didn't recognize. role after complete enactment.
Doctor	1. "Now, children, let me examine you." Makes gesture and motion to hold child's head. Uses doll. Takes a stick (tongue depresser) and attempts to put it into doll's mouth. "Now what's happened to this little girl? She has broken her neck. I will put something in it." Takes scissors and cuts strips of paper. 2. "Now here are some pills for her." 3. Puts pieces of paper on child for bandage, and makes gesture of giving pills. 4. "Now how much is that?" 5. "It's $50."	1. In weak voice: "I take care of people when they're sick."
Mailman	1. Asks for something to represent letters. Is given empty envelopes. Walks towards various spots in the room slipping them behind chairs, saying: "This belongs to Miss Tara. Where's her mail box?" 2. Throws letter behind chair. 3. Takes another, saying: "This is a card for Mrs. Jones. Here's her mail box." Likewise throws it into space behind another chair. 4. "This belongs to Mrs. Sweet," and so on, putting them all in different places. 5. "He now goes back to post office."	1. "What am I doing? I'm giving letters." Stands still. Makes gestures with her hands as if dealing out letters.
Minister	1. "I don't like that one." 2. Stands up straight as if facing an audience: "All right, say your prayers." 3. "All right, we're ready to sing." "O.K."	1. "Don't know it." Perception: After complete enactment says: "Person in church; priest?" (She is a protestant.)

	RITA	KAY
	4. Makes motion of pulling rope of church bell, saying: "Ding, ding, ding." 5. "O.K., everybody out." 6. Makes imitative gesture of opening the doors. 7. "Now he stands there and talks." 8. "They just pray and sing."	
Taxicab Driver	1. "Is this your stop, lady?" 2. "Where do you two ladies want to go? Amusement park?" 3. "Where do you two ladies want to go?" 4. Has hands around wheel, makes motion as if driving, saying: "Honk, honk." 5. "All right, here's your stop." 6. "Toot-toot." 7. "The swimming pool? All right." 8. "Is this your stop? How much money?"	1. Puts hands up as if on wheel, driving car: "Chog-a-chog." 2. "I have to stop and let people on." 3. "Now I'm going to pull the brake." Makes motion as though pulling the brake.
Lawyer	"Oh, that's too hard. I don't know." ——————— Perception: "don't know."	1. "Don't know." ——————— Perception: "Don't know."
Plumber	1. Gets way down on stomach, saying: "I have to look at this sink. Have to get this ring out of here. Here, little girl, is your ring off the pipe." (a) "Anything else? Pipe is broken? Well, I'll have to go out and get my tools." 2. Goes out of the room, comes back with some sticks. Grunts: "Ooooh!" as she gets down. "Have to get this nail in here." Works on it for some time. 3. "Oh, darn it. There, now." Polishes it. 4. Now I've got to take my tools and everything away." Takes objects and walks out of room.	1. "Don't know; I don't know." ——————— Perception: "Don't know."
Railroad Engineer	1. Holds hand up as if hanging on to something: "This is the wheel. I'm driving it." Aside to adult: "He doesn't call out the stations. He drives the engine."	1. Don't know how to act it." ——————— Perception: "Train driver." After a pause: "Engineer."
Conductor	1. "Your tickets, please." 2. "Hornell, Hornell, next stop." 3. Walks as if walking up the aisle of train and looks from one	1. "I take tickets." "What shall I do? I don't know."

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	RITA	KAY
	side to another, leaning over as if taking tickets from passengers. 4. He says: "Come on the train. Hurry up." (An aside to adult.)	
Mother- Father	1. "I shall wash the dishes and make the house tidy." Moves about making motions as though sweeping. 2. Changes her voice to lower pitch: "I shall work and go to work hard in factories—earn some money and gold. I go out to chop wood and saw it." 3. Changes position again and voice: "I mop the floor; cook for the kiddies. I shall go out and sweep the floor."	1. "Don't know." ——— Perception: "Mother and father." Recognized the role after complete enactment.
Banker	1. "How much money do you earn? I have to." 2. "Now I can get my checks out. Here's my own checking desk. I'll give out money to people." 3. Takes up telephone and says: "Are you coming to the bank, too?"	1. "Don't know." ——— Perception: "Don't know."

The foregoing sample of responses show the two extreme reactions of children both above the average in intelligence, the one, Kay, of the superior intelligence being unable to warm up to enacting most of the roles, along with having a surprisingly low level of role perception. This same child showed also a comparatively low s factor in spontaneity tests. She is a sensitive, intuitive child with superior musical ability. She was from early childhood fearful of other children, and until the age of four, cried continuously when approached by other children in a group. An early sociometric study (1) had been made of the particular nursery school of which she was a member, and her position was that of an extreme isolate.* In the last two years, her development has changed considerably. She has become the aggressor, has appeared anything but inhibited in her social relationships, and, upon superficial observation, one might call her "much more spontaneous." However, when placed in specific spontaneity tests recently, her *social* spontaneity still seemed to lag. In the role tests, she reacted enthusiastically to the "game" idea, and although she saw a sample of a performance, and could *describe* what some of the various roles were, she was

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*In the article, "Sociometric Status of Children in a Nursery School Group," *Sociometry*, Vol. 5, No. 4, November 1942, Kay goes under the name of Mildred, and Rita, under the name of Florence.

unable to warm up to their enactment. Rita, in contrast, is not so capable in musical ability as Kay, nor so meticulous in writing and manual dexterity, but has shown a high s factor on other spontaneity tests. Her sociometric position in the same nursery school was neither that of isolation nor extreme popularity. She had, however, a far greater number of incoming choices, but reciprocated the choice of only one child, with whom she appeared to play the most throughout the study. In sum, Kay is far less resourceful in meeting emerging situations, particularly social, is much more bound to stereotypes, as is apparent in her musical expression and in drawing tests. Taking Kay's low role score and the foregoing factors into account, there are indications that a low s score goes hand in hand with a low sociometric and a low role score.

TABLE 1
ROLE SCORES
(Number of Roles Scored: 15)

	Number of role enactments	Number of role perceptions	Enactment below level of recognition	Partial enactment	Distorted enactment	Adequate enactment
Rita						
(6 yrs., 4 mo.)	14+	13+	1	7		5
I.Q. 118	1—	2—				
Ella						
(6 yrs., 9 mo.)	13+	13+		9½	½	2
I.Q. 135	2—	2—				
Jerry						
(6 yrs., 2 mo.)	9+	9+	1	7	1	
I.Q. 108	6—	6—				
Freddie						
(8 yrs., 6 mo.)	7+	5+	3	3		1
I.Q. 85	8—	8—				
Kay						
(6 yrs., 2 mo.)	2+	7+	1	1		
I.Q. 140	13—	8—				
Jean						
(4 yrs., 10 mo.)	0	7+				
I.Q. 120		8—				

Key: 9+ means that nine out of the fifteen roles were enacted.
Example: 6— means that six roles out of the fifteen roles were unenacted

TABLE 2
ROLES ENACTED
(Total Number of Roles: 15)

	Jerry	Jean	Freddie	Kay	Ella	Rita
Policeman	x		xx		xx	xxx
Teacher	x				xx	xx
Lawyer		x				
R.R. Engineer			x		xx*	xx
R.R. Conductor			x		xx*	xxx*
Storekeeper	xx		xxx*		xxx*	xx*
Judge						x
Mother-Father	xx				xx	xxx
Brother-Sister	xx				xx*	xx
Doctor	x				xx	xx*
Banker					xx	xx
Taxicab driver	xx		xxx	xx*	xxx*	xx*
Mailman	xx		xx	xx	xx*	xxx*
Minister	xx*				xx*	xx
Plumber					xxx*	xxx*

Key:
  x means enactment *below* the level of recognition.
  xx means *partial* enactment.
  xxx means *complete* enactment.
  * means that this particular role has been enacted with the greatest degree of dramatic quality, that is, the intensity of warming up to the role, the longest duration of enactments, or the greatest amount of details with respect to gestures and verbalizations.

ANALYSIS

For the purposes of refining the scores, and in order to give as much credit as possible to all attempts at enactment, the scoring has been divided into various levels of performance, as follows:

(a) *Enactment below the level of recognition* means the inclusion of elements remotely related to the role but not sufficient for its recognition.

(b) *Partial enactment* means including one or two recognizable phases of the role.

(c) *Distorted enactment* means the enacting of characteristics largely unrelated to the assigned role. The child may include bizarre formations of the role.

(d) *Adequate enactment* means the inclusion of all significant phases of the role as evaluated by the jury.

Role Stability

Ella and Rita have the highest role range, 14:1 and 13:2. Both are above the average in intelligence with Ella leading by about ten points.

Although Ella is a few months older than Rita, and of higher intelligence, Rita is about equal to her in role performance. These figures, however, do not reveal the great qualitative differences in their performances. For instance, in certain roles, Ella was far more dramatic than Rita, in the sense that she chose to elaborate upon one or two phases of a role with extensive gestures, movements, and verbalizations, rather than to include all phases of the role as Rita did. This excessive dramatization on the part of Ella led into role instability; the fact that she was unable to contain herself within the roles enacted shows that the thresholds between her roles were thin. She was so carried away by the dramatic aspect of her spontaneity that she did not visualize a complete pattern of the role with its closures; that is, her undisciplined spontaneity carried her, upon the suggestion of a role, from one role to another. This produces, furthermore, an uneven *clustering of roles*. The following is just a sample of this point in her role of the "teacher":

"Children, you must read today. You must learn your lessons well and everything else. If you do your lessons well, we will go to the museum. We will have to ask our principal, Mrs. Brown." She then became slightly grotesque, swayed back and forth with her arms raised up, still facing the audience, however, and said: "I'm the biggest fattest lady in the circus." And then, became a barker in the circus, and shouted: "Right this way to see the elephants and clowns, right this way, etc."

Rita, on the other hand, in certain roles, included all significant phases briefly and finished in half the time of Ella's performance of one or two aspects of a role. However, in other roles, Rita was highly dramatic and enthusiastic, but at no time on an *uncontrolled* spontaneous level.

Relationship of Intelligence to Role Scores

The results are not complete enough to draw any definite conclusions concerning the relationship of intelligence to cultural maturity. However, Table 1 indicates that high intelligence *may* cause a higher role score, but not necessarily, as is evident in the situation of Kay, who, though only seven months younger than Ella, is disproportionately inferior to her in role performance. This strengthens, furthermore, our previous assertions that the Binet intelligence test is limited, insofar as it is not able to measure role behavior. As the study is in progress and is extended to a larger number of children, more refined role scores will be derived, and eventually role quotients, which can be correlated with intelligence quotients.

Individual Responses of the Same Role

We are able to study the degree of cultural differentiation to a great extent from Tables 1 and 2. Highly important, too, is the cultural differentiation with respect to its interpretation. In the role of the policeman, for example, he was regarded by two of the children as a sort of robot director of traffic. Rita has presented him as a traffic policeman (with more flexibility than that of a robot), as one who has the power to arrest people, and as one who deals with gangsters, involving shooting and killing. Freddie emphasized only arresting and going to jail. In the mother and father roles, Ella, Rita, and Jerry respectively emphasized the maternal-paternal-child relationship, hinting at the conflicts involved; the specific duties of each parent, such as domestic and the role of supporter; and the mother alone, particularly the maternal and domestic aspects. The following illustrations confirm this:

ELLA	RITA	JERRY
In a high voice: "Now honey, you must sit down and have your breakfast. Susan, *do* it. Daddy said to *do* it. I'm going to turn you over my knee and spank you. You're going to bed." She changes her voice to normal, and says: "Now I'm dad." Changes her voice to a lower pitch: "Mother, what are we going to do with this girl? She's not good at all. Now you go to bed; now, say your prayers . . ." (uses teddy bear) Pretends to put it to bed. Changes voice: "Now, I'm Mom." "I have to fry an egg. Darling, hold your plate out. I spent a long time at it."	"I shall wash the dishes and make the house tidy." Moves about as though sweeping. Changes her voice to lower pitch: "I shall work and go to work hard in factories— earn some money and gold. I go out and chop w o o d a n d s a w i t." Changes position again and voice: "I mop the floor; cook for the kiddies. I shall go out and sweep the floor."	"Come on, baby, you have to go to sleep, now. Rest your legs." Makes motions as though laying a baby down. "I guess I'll straighten the house up." Starts to pick things up in the room, losing herself completely in the role, as she goes about systematically to clean and and rearrange the room she is in. Spends considerable time at this, and would have gone on doing so if tester did not terminate this particular scene. She was prompted by tester: "What about father?" She answered: "Oh, he does the work with things. Comes home, eats his lunch and eats again. Goes back to work shop to fix things." Tester says: "Show us." Seems unable to warm up to action in role of father.

*Role Dominance as a Factor Influencing
Interpersonal Relations*

We see from Table 2 that all the children, with the exception of Jean, enacted the roles of the taxicab driver and the mailman. In the role of

the taxicab driver, three of the children were particularly strong. The storekeeper was enacted by four of the children. The lawyer and judge were out of the present cultural range of all of the children. Diagram 1 shows the interrelationship of roles, pointing out the clashes of dominant roles, which is an important explanation for the attractions and repulsions of Rita, Ella, and Kay. It can be seen here that Ella and Rita are mutually strong in certain roles. It is not surprising then that when the three girls are together, there is bitter conflict between Ella and Rita for role dominance over Kay, who has only two roles which are important to her and at the same time to her two companions. When Kay is alone with only *one* of the other two girls, their strong roles realize their fulfillment in Kay's passive responses to them. When the three girls are together, Rita and Ella are struggling to overcome the counter-spontaneity and counter role dominance of each other, and competing to exercise their role powers over the weaker Kay. The conflicts among the other children are less noticeable possibly because of their weak role ranges and weaknesses in warming up to enactments altogether. Jerry and Rita appear quite compatible in their play; this may be attributed to Jerry's strong mother role being complemented by Rita's weak mother role, and Jerry's strong minister role being balanced somewhat by Rita's verbal rejection of the role, even though she attempted to enact it. Thus, it can be seen, due to the findings of the role test, that the charting of attractions and repulsions can be further elaborated by role diagrams. It reveals a deeper interpersonal structure, breaking up, on the one hand, the individual into the roles in which he manifests himself, and, on the other hand, giving the attractions and repulsions phenomena a socially tangible reality.

GENERAL DISCUSSION

One of the outstanding features of this study is the problem of *enactable* and *unenactable roles*. Why is it, for instance, that in some cases the most easily enacted roles come from the more remote social experiences rather than in the immediate primary experiences, such as in the home and/or school? Why is it that some children appear to derive a certain thrill or excitement out of experiencing the roles of the taxicab driver, mailman, or conductor rather than the mother-father roles? Why is it that some children need to objectify the roles and define them within themselves, perhaps verbally or pictorially, before they are able to enact them, while other children warm up immediately to certain portions of the role with no apparent plan of action?

We recall that for the same children—when they were three to four years old—the exciting thing was to play mother, father, brother and sister. Now, little more than two years later, these roles are apparently taken for granted. In their expanding world other roles, like policeman and mailman seem much more adventurous. But these observations have a deeper and more fundamental explanation still. It is based on the theory of the matrix of identity.*

Before elaborating upon an explanation, a summing up of our conclusions drawn in an earlier paper may be appropriate. According to spontaneity theory, the infant is not thrown into the world without his participation. He plays a fundamental part in the act of birth. The factor by means of which the infant is self-propelling himself into life is called spontaneity. This factor is aiding the infant during the first days to maintain himself in a strange new world against great odds. At a time when memory, intelligence, and other cerebral functions are yet little developed or non-existent, the s factor is the mainstay of the infant's own resourcefulness. To his support come the auxiliary egos and objects with whom he forms his first environment, the matrix of identity. We differentiated between (a) a period in the child's infancy for many phases of which he has later a true amnesia, and (b) a period in the child's infancy in which the function of dreaming develops and in which the functions of memory and intelligence gain in strength. It is probable that for certain children the matrix of identity is extended beyond its usual time point of termination. They apparently need a prolonged period of psychological incubation (mother, father, and other auxiliary egos being the helpers).

Due to the co-experiencing of the maternal or paternal roles, the roles become so much a part of the child's self, that it is easier for him to "be" them in a spontaneous casual activity than it is for him to act the roles out, on the spur of the moment, when presented with the verbal stimulus "act the mother". The more these roles have become a part of the self, the more difficult it will be in later years for the child to enact them, particularly when he attempts to put them on the level of conceptual learning, for it is in the earliest stage of role assimilation (matrix of identity) that the child is experiencing a form of living which is pre-*un*conscious as well as it is pre-conscious; it is strictly act living. The later way of assimi-

*Moreno, J. L. and Moreno, F. B., "Spontaneity Theory of Child Development," *Sociometry*, vol.

lating a role is through conditioning, perception, and objectification. Since one of the first role experiences is the mother role, it can be seen how difficult it might be for a child to reproduce it when he attempts to put it on the level of objectification and perception. It is difficult to give birth to a role which is fully integrated into the self. It is with the parts which are *un*integrated that he is able to act out a role, carrying with them the parts of the role which have been apparently dissolved within the self. Social roles such as policeman, doctor, etc., are obviously more or less unintegrated into themselves to start with. In principle, at least, the difficulty of enactment is less great. Children are far more dependent here upon their ability to perceive their social significance. However, the spontaneity with which they warm up to them, they apparently draw from older role connections (mother, father roles) which are deeply integrated into themselves. For the child, furthermore, who attempts to put such roles as the mother and father on the conceptual level, the clustering of roles within the mother and father roles complicates warming up to their enactment. However, although unenactable, there seems to be a transfer of spontaneity from these role clusters to other roles, for example, from father to policeman, etc.

Therefore, children who enact the maternal or paternal roles, for example, easily without any preparation are those who have been greatly impressed with the social and more immediate aspects of the role and are able to keep these fairly well apart from the older and deeper experiences of it. Since "the mother" is not a single role but a cluster of roles,* certain of its older manifestations may be deeply disturbing to a child and so puzzling that she is not able to enact them; for other parts she may have a true amnesia (not merely "forgetting" because of repression in the psychoanalytic sense). This sums up to the following: Certain children are able to confine the mother experience to its social and surface manifestations, and thus they can objectify and enact the role. Other children cannot confine the role to its immediate social context. They are, at least within themselves, if not also externally more deeply dependent upon co-acting with the mother in a mutually developed matrix of identity, so that these children are, perhaps, less mature, and, for this reason, more spontaneous. By this trick of their minds, they can draw also from the spontaneity of the mother as if it would be their own.

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*The mother role might include a clustering of such roles as wife to the father, companion to him, homemaker, nurse to the child, etc.

For certain children, even socially facile roles, such as the plumber, storekeeper, etc., seem difficult to enact. It seems that their ability to transfer the s factor from earlier configurations is weak. On the other hand, their dependence upon their perception, via memory and intelligence, is an insufficient impetus to enactment. They will have to become much older and more mature until their weak spontaneity will be amply compensated by a fuller comprehension and assimilation of role-stereotypes and conserves. For all children of this study, it remains to mention that certain roles have been unenactable, such as the lawyer and the judge, because they have not yet entered their orbit of experience.

Conclusions

1. The role test is based upon the premise that roles are the most important single factors which determine the cultural character of individuals.

Working with the "role" as a point of reference appears to be a methodical advantage as compared with "personality" or "ego." These are less concrete and wrapped up in metapsychological mysteriousness.

2. In the two processes examined, role enactment and role perception of children, it was found that the perception of a role does not automatically mean the ability to enact it. On the other hand, there are children who are spontaneously able to enact a role beyond the degree of perception; the s (spontaneity) factor is operating.

3. Roles are not isolated; they tend to form clusters. There is a transfer of s from unenacted roles to the presently enacted ones. This influence is called *cluster effect*.

4. There were roles with which the subjects were intimately acquainted, but still, when put to the test, they were unable to enact them.

5. The set of roles considered pertinent varies in the two projects, A and B, studied. The results indicate that anthropological studies will profit from comparing the findings of role tests given to primitive societies and to ethnical minorities and ruling groups in our own country.
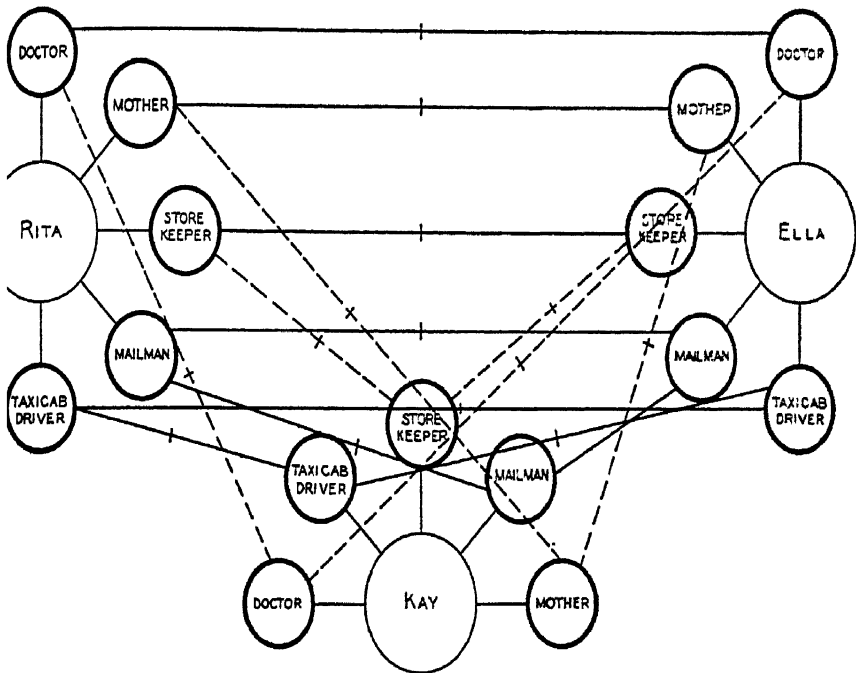
ROLE DIAGRAM

EY:

———|———: MUTUALLY ANTAGONISTIC
——·|——·: MUTUALLY COMPATIBLE

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SOCIOMETRIC METHODS

SOME APPROACHES TO GROUP PROBLEMS IN THE BRITISH ARMY*

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Lt.-Col. A. T. M. Wilson, R.A.M.C., Specialist in Psychiatry.

Major W. R. Bion, D.S.O., R.A.M.C., Specialist in Psychiatry.

Major S. H. Foulkes, R.A.M.C., Specialist in Psychiatry.

Major J. Rickman, R.A.M.C., Specialist in Psychiatry.

Lt.-Col. E. L. Trist, Senior Psychologist to the War Office Selection Boards.

Lt.-Col. H. Bridger, formerly a Military Testing Officer and now commanding a Civil Resettlement Unit.

In the course of the war, the psychiatrists in the British Army were confronted with a number of problems which were appreciated by them to belong to the institution of the army as a whole or to groups within it and which accordingly could best be treated by methods dealing with the dynamics of the group in its total setting. These problems were new to the psychiatrists who therefore had to tackle them without previous direct experience of what was involved. As successive tasks were dealt with, a degree of clarification accompanied the increasing and widening experience. While the measures taken were spoken of at the time as "psychiatric," it was realized that the traditional frontiers of psychiatry had been greatly extended and that the psychiatrists, and the psychologists who later joined them, were in fact in new rôles in relation to the groups they were treating. It was later recognized that this independent development had features in common with certain trends in America where the term "sociatric"** has

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*This report has been passed by the British War Office Public Relations Department for publication. Because of the hasty conditions under which the paper had to be prepared, it does not purport to be more than a *preliminary* report.

It is planned to release the fuller statements in SOCIOMETRY at a later date.

**See J. L. Moreno, "Who Shall Survive," p. 192; also, *Sociometry*, Vol. VI, No. 2.

been introduced to describe measures of this kind for group problems. It is as yet too soon to describe these developments fully but it is hoped that the various workers concerned will do this in due course. The purpose of the present article is merely to give a very brief indication of some of the group techniques used and some of the considerations leading to their introduction. The present authors have been engaged chiefly in selection problems with the result that these are dealt with more fully.

At the outbreak of war a Consulting Psychiatrist (Brigadier J. R. Rees) was appointed to the Army and early in 1940 he selected a team of psychiatrists to develop a psychiatric service for the Army. These psychiatrists had all been engaged in psychotherapeutic work with the neuroses and shared a dynamic psychological viewpoint largely deriving from psychoanalytic thought. Most of them were also interested in the wider social aspects of the neuroses and their prophylaxis. It is difficult to state what the particular contribution of this background was in determining the steps taken by the Army psychiatrists, but it probably made it easier for them to evolve, as they did, therapeutic procedures applicable to the institution as a whole, and in the evolution and operation of these procedures, to seek from the start the participation of the "lay" members of the institution in an active way. For what characterizes effective analytic treatment is the active participation of the patient in working out its rationale.

The General Service Scheme

One of the first instances of a procedure to deal with a problem of the whole institution was the General Service Scheme initiated largely by Hargreaves. The basic aspect of "the field" in the early stages of the war was that Britain was faced with the necessity of building up with the utmost rapidity its fighting services and its war industries. In the resulting competition for man-power no individual could be rejected from the Army unless it was clear that he could not be employed in any capacity in it. It had been expected that there would be psychiatric casualties arising from the stress of active service but what had not been foreseen was the extent of the psychiatric breakdown rate during training amongst those who had no experience of action. It became apparent that one of the most important causes of difficulty in adjustment to the Army was unsuitable employment within the Army itself. A large number of soldiers were occupied in work which was either above or below their capacity and, in either case, dissatisfaction, poor morale and even breakdown were apt to follow.

The value of selection tests was well known to the psychiatrists who, as well as some civilian psychologists, had carried out experiments with these in the Army. But the nature of the situation was such that it could be met only by introducing measures which effected a radical change in the field and in addition satisfied certain specific requirements of the field. These were that the measures should be acceptable to the psychologist in that his participation was scientifically adequate, to the Army in that its representatives preserved their executive rôles and contributed their experience, and to the recruit in that techniques used should appear relevant to his situation. These aims were achieved by setting up a Directorate for the Selection of Personnel to be responsible for the General Service Scheme. The Directorate was controlled by a senior Army officer who had as technical advisers for the task of creating a selection machinery psychiatrists and psychologists, the latter being given military appointments for this purpose. There were few qualified psychologists available and after the general planning was completed, most of their time had to be devoted to the creation of suitable tests. To operate the scheme, with the large numbers of recruits involved, regimental officers were selected and trained as Personnel Selection Officers whose function was to use the results of the selection tests along with the data from interview of the recruits and on the basis of the findings to decide for what kind of job in the Army each recruit was suitable. The Personnel Selection Officer referred certain problem groups (e.g., those of low intelligence) and any individual problem cases to a psychiatrist for special advice on disposal. The operation of the scheme involved a change in the structure of the Army. Previously enlistment had taken place directly from civil life into the various infantry regiments and other corps.

It was determined partly by the individual's expressed preference and partly by the demand situation of the various arms at the time. Under the new scheme, Primary Training Centres were set up into which all recruits were enlisted. There they received basic army training in the course of which the selection assessment was made. Hence the recruit's first contact was with the Army as a whole and not with a particular branch of it. Further, the fact that one of the first actions of the Army in its contact with the recruit was to study him seriously with a view to finding out how he could best be employed, made the whole procedure relevant and acceptable from the recruit's point of view. The result was that the measure not only had a prophylactic value in the sense that it tended to reduce the

incidence of unsuitable employment as a cause of disability, but also a therapeutic value in its effect on general morale.

The fact that the General Service Scheme with its extensive use of psychologists and psychiatrists is now taken for granted as part of the Army is evidence of its effectiveness in dealing with the problems for which it was devised. There would seem to be little doubt that his acceptance has been secured not only by the adequacy of the selection techniques, but by the satisfying nature of the participation which the scheme has permitted to all parties.

Officer Selection—(a) *Evolution of an acceptable scheme*

The General Service Scheme applied to Other Ranks only, but the situation at officer level had also become unsatisfactory. The rapid expansion of the Army and the increasing proportion of officers required by the needs of mechanized warfare had demanded a vastly increased supply of officers. Under this demand, the system which had been in use for officer selection showed signs of breaking down and steps had to be taken to remedy this. Army psychiatrists had, by this time, accumulated a fund of experience on officer problems so their opinion was again sought when the question of improving the quality and quantity of officer supply became acute. Again the job of the psychiatrists engaged in this work was to forge an instrument which was part of the Army in that it made full use of both the experience and the traditions of the Army and of the resources of the psychological sciences. It would have been possible to construct a scheme for officer selection in which psychologists and psychiatrists applied their methods to the problem while the Army made use of their results, but to do so would have been to introduce a "foreign body" into the tissues of the Army which would have provoked an inevitable defense reaction. This would have made the selection task much more difficult to begin with and impossible eventually. It was considered, therefore, that the Army itself had to be fully responsible for the solution of this particular problem and that the instrument of selection evolved should be of such a nature that the Army could demonstrate its acceptance of this responsibility. The task of the psychiatrists then was to work within the framework of the institution and, at the same time, to educate the institution itself so that the method evolved should both spring from it and influence it.

The solution which resulted from this situation, largely the work of Rodger, was the War Office Selection Boards. A W.O.S. Board can be

defined as a military group whose function is to make an assessment of personality in either officers, or applicants for commissions, with a view to determining their suitability for various officer rôles in the Army. It consists of a President and Deputy President, Military Testing Officers, and a Psychological Department which has a psychologist and a psychiatrist. The President, who is a senior Army officer with wide experience of the Army, is responsible for the decisions made by the Board. In his executive capacity he represents the Army to the candidates and in the eyes of the Army he acts as a guarantee of the procedure. The Military Testing Officer is a regimental officer usually with experience of battle conditions, who is more nearly contemporary in age with the candidates. He has a dual rôle in that he has not only to observe and assess the candidates' performance on certain tests, but also to look after them throughout their stay at the board. The psychiatrist's function is also twofold. He is the medical examiner who assesses the candidates from the point of view of psychological fitness for the officer rôle and his medical status assures the candidate that his examination will be conducted without prejudice. He is also the scientific adviser to the President in the evolution of test procedures, and in this rôle he works in close coöperation with the psychologist.

The details of the testing procedure used are not relevant to this article but two group techniques might be mentioned which are prominent features in it. The first of these was introduced in connection with the assessment of one of the most fundamental aspects of officer suitability, namely, the quality of the individual's social relationships. Bion formulated the view that one way to assess this was to put the candidate in a setting where the quality of these relationships was tested in a psychologically direct and real situation and for this purpose he evolved the method of "Leaderless Groups." He stated the principles underlying this method as follows: "The Leaderless Group Tests are intended to display to their fullest extent those general qualities of personality that are of equal value or of equal danger whatever the duties their possessor is engaged in. These qualities are displayed in the interpersonal relationships that form a marked feature of the Leaderless Group Tests. The function of these general qualities that are observed is best described by the psychiatrist's use of the word 'contact,' that is to say, the capacity for mature, independent social relationships."

These tests are applied to candidate groups in whom the optimum number is eight. To be brief, the method consists in presenting to the

group a problem of some kind, verbal or practical, and leaving the group entirely free to work out its own solution. The merit of the method is that it forces the candidate to make some revelation of the quality of his social contact by making use of his anxiety to do well for himself. In individual tests the candidate's desire to do better than other candidates presents no problem but when the testing officer puts him through his test as a member of a group without a leader and not as an individual, a problem is introduced. The anxiety to look after his own interest remains but the testing officer has given an instruction which calls into activity not individuals but a group formed by those individuals. Moreover, he has given no indication whether he means to judge the performance of individuals or the performance of the group as a whole. A conflict therefore arises and the candidate finds that he can only demonstrate his abilities through the medium of others, and this being true of everyone in the group a common purpose is created, namely, so to act to one another that each individual will have an adequate opportunity to display himself. The Leaderless Group method, therefore, sets two types of problem:—

    (i) the real or social problem, that is to reconcile group purpose with individual aspirations, and

    (ii) the quasi-real, or set problem, that is the particular test situation. The real problem is only sensed by the candidates, it is concealed by the operational problem which is set and to which the candidates direct their attention. From the point of view of the observers, it is the real problem which engages attention. Their task is to identify what is spontaneous in the behavior of the members of the group and through this to get some indication of their "group cohesive" and "group disruptive' tendencies.

    The need for the second group technique largely arose out of the situation created by the use of the Leaderless Group Tests. At the W.O.S. Board each candidate is judged by three observers, President (or Deputy President), a Military Testing Officer, and a Psychiatrist or Psychologist. Originally the observers worked independently during the testing period and met to pool opinions at a final conference. It was difficult in practice to maintain strict independence under these conditions. The President and Psychiatrist had interview rôles only and there was created in them a certain "tension" because they lacked the opportunity of seeing the candidate in action—a source of data they need to make a rounded judgment. On the other hand, the Military Testing Officer experienced a corresponding need to have data about the life-history of the candidate in order that his

"cross-sectional" view which he obtained from the practical tests could be properly interpreted. Further, at the final conference discrepancies could not always be resolved to the satisfaction of all observers because one or other felt in these cases that his "judgment" had been deemed "wrong" without what was to him sufficient reason. To remedy this situation it was thought that what was needed was a method of "socializing" the judgment process. In brief this was achieved by combining the three observers into an observer team whose task was to reach group judgment. The team now begins this task by considering certain evidence in common. Each member is provided with relevant data about the candidate's background and then the team observes a series of Leaderless Group Tests early in the Board procedure. At the end of this series a "query conference" is held at which the members of the team interchange freely initial impressions of the candidates. This interchange enables the group to make alternative hypotheses about those candidates on whom there is a difference of opinion and then to decide which member of the team is likely to obtain evidence that will be critical. From this point in the testing program each member occupies his specialist rôle as an investigator, the President and Psychiatrist or Psychologist as interviewers and the Military Testing Officer as an observer of further special test situations. At the end of the testing program there is a further interchange of judgments and then each member makes his report independently for a final conference at which all the evidence is considered. The observer team with its definition of rôles for each member has largely dissipated the tensions referred to previously and reduced the danger of unsatisfactory rôles creating inter-personal relationships between the judges which adversely affect the judgment process.

Officer Selection—(b) Candidate Supply

As indicated earlier, the problem was not only improving the quality of officers by suitable selection methods, but also that of improving the actual supply of candidates for commissions. The usual method of application was for the candidate to be recommended for a commission by the Commanding Officer of his unit, but a survey of sources of supply carried out by Trist showed that some units put forward far more candidates than others and since there was no reason to suspect such wide differences in quality between these units, it followed that the possible sources were not being fully tapped. Bion suggested that use might be made of the knowledge which any group possesses of its own resources and, to mobilize this

knowledge effectively, the men in good units might be awarded the privilege of nominating candidates to appear before the W.O.S. Boards. Trist (who had entered the Army after the start of the W.O.S. Boards pointed out that this was in fact a real sociometric procedure and he suggested that sociometric methods should be employed.

The participation of all the relevant authorities was secured and an experiment was put into operation along these lines. A number of units were chosen by an Army Commander varying in size from Infantry Battalions down to isolated companies, but each composed of a number of small functioning units, e.g., platoons in the case of Infantry. At a specified time each complete unit was paraded and all members of it were asked to write down on a piece of paper the names of all those whom they felt were suitable candidates for commissions. It was explained that they should be sure to choose good candidates because it was quite likely that in due course some of those chosen would return to the unit as officers. Choice papers were completed anonymously with the men, the senior N.C.O.'s, and the junior officers working in independent groups.

From the result, various choice patterns were worked out. For each individual nominated it was possible to compare the choices he received within his own platoon, those originating from outside his own platoon, but from the same Company or Battalion, those originating from N.C.O.'s and those originating from officers. Finally, the Commanding Officer gave his own list and his opinion on all the nominations. The results obtained were on the following lines:

A few soldiers received outstanding suport from all sources. Then there was a break followed by a much larger number of soldiers with less support or with support confined largely to one category, e.g., a man might be strongly supported by his own companions within the platoon but not outside it and not by N.C.O.'s or officers. It was decided to call up for examination by a W.O.S. Board all those who had received an appreciable measure of support from any source. From this it became clear that many of them had received support largely because they were regarded by their own companions as group leaders in those problems which the men felt to be their own. An appreciable difference in the quality of the social atoms of many of these candidates was noted. In many, an apparently negative attitude to authority had been determined entirely by the field in which they were placed and did not reflect any unsuitable basic personality trends. A number of these did not want commissions when they arrived at the

W.O.S. Board but changed their minds when the misconceptions and the negative attitudes based on these were dispelled by their experience at the Board where the usual barriers between officers and men are much more permeable.

The conclusion was that this method of selecting candidates produced a number who would not under ordinary circumstances have appeared at a W.O.S. Board, and that of those many were quite suitable for commissions. A more extended trial of the method was planned but it was not possible to carry it out for various reasons, one of which was the fact that the introduction of the W.O.S. Board procedure had, in itself, largely solved the problem of supply. Its fairness as a method of judgment had made a wide appeal and had largely removed the doubts and hesitancies which had been interfering with the flow of candidates.

Training

The intensive study of personality, which was intrinsic in the work of W.O.S. Boards, focussed attention on certain specific problems. One of these was the problem of immaturity. Boards were constantly being faced with candidates in the 18 to 22 age groups who gave the impression that in time they would be suitable officers but that they would require more development than would ordinarily take place during a course at the Officer Training School. An attempt was made to deal with this problem by setting up a special training centre, to which these candidates could be sent for a course of intensive training lasting some 10 weeks. The idea was that this should develop their self-confidence and accustom them to the idea of responsibility, and that after the completion of this course they should be re-assessed by another W.O.S. Board to see whether they had developed sufficiently to proceed to Officer Training School.

At this training centre each intake was divided into platoons and these into sections, the initial division being purely on a random basis. At fortnightly intervals during the training period a sociometric test was carried out by sections throughout the whole intake, each student being asked to rank those in his section, putting the one whom he considered would make the best officer at the top, and the others in order down to the last, or the least likely to make a good officer. In addition, the student was asked to write down briefly the reasons for his choice in the case of the first and the last. The results from these tests were used to reform the sections and platoons, the best being put into one platoon, then the intermediate into

another, and finally the low ranking into a third. The result was that at the end of the training period, what could be called a "creamed" platoon had separated out, containing in it all students who had been effective in their groups from the beginning of the course, and similarly at the other end. Further, by comparing the rankings achieved by each student throughout the course, it was possible to get a fairly clear idea of his progress and relationship with the others. The value of these results to the W. O. S. Board which saw the student at the end of the course does not require to be stressed; but an interesting point which emerged was the fact that the changeovers became less and less difficult. The resquadding after the first sociometric test usually resulted in a difficult period, but after the second and subsequent tests adjustment was much more rapid. By this method, students tended to find their own level, and by the end of the course a situation had been created in which no student was overshadowed by any of his immediate associates.

A similar technique was employed at another training centre, the purpose of which was to give infantry training to those who were applying for commissions in infantry but who came from other arms of the service. Since this centre provided a set course of training the results of the fortnightly sociometric testing were not used for resquadding. The students remained in the same groups throughout their course with the result that the sociometric tests enabled a progress chart to be made of the status of each individual in his own group. At the end of a weapon training course lasting six weeks there was a further three weeks' battle training of a much more strenuous type. The effect on ranking which this change produced was often highly informative.

One of the most interesting and instructive investigations carried out during a training period was a study of platoon life by Main. His approach to this was determined by his experience of the Leaderless Group technique and in his study he applied both sociometric methods and leaderless group methods. This involved giving the platoon a number of different jobs to do and watching the spontaneous groupings which formed as well as investigating the groupings which took place in the barrack room and off duty in the canteen. To this approach Main added the use of sociometric tests and personality studies of the group members by means of psychiatric interviews.

Group Therapy for the Neuroses

The study of leaderless groups at W.O.S. Boards led Bion to the consideration of the possible application of group methods to the treatment of neurosis as a social problem in the Army. In collaboration with Major J. Rickman, R.A.M.C. he carried out a study of the possibility at a military psychiatric hospital. Pointing out that the term group therapy could refer to the treatment of a number of individuals assembled for special therapeutic sessions or to a planned endeavor to develop in a group the forces that lead to smoothly running coöperative activity he used this latter conception to work out his treatment program. His object was to deal with the situation by attempting to display neurosis as the real problem of the group and one which would be worthy of communal study and attack. He felt that if the recognition of neurosis as a common enemy were achieved then the group would discipline itself to deal effectively with the common danger. With this object in view he concentrated on the development of groups in the training wing of the hospital. He stipulated that each man had to be a member of one or more groups designed to study handicrafts, Army correspondence courses, carpentry, etc., but any man could form a fresh group if he wanted to do so—either because no group existed for his particular activity or because for some reason he was not able to join a similar existing group. A parade was held each day at a fixed time lasting 30 minutes. The ostensible object of this was that it provided an opportunity for making announcements and conducting other business, but the real intention was that it should develop into a therapeutic seminar, e.g., providing an opportunity for free discussion and eventually self-criticism.

Early in the experimental period groups were formed readily, but it became apparent at the same time to both the Psychiatrists and the patients that very little was happening. The freedom granted to the group for spontaneous activity began to cause no little anxiety in the patients. A small proportion complained that the large majority merely took advantage of the freedom to do nothing and that no steps were being taken to stop this. Bion took the view that their concern over the social effects of neurotic behavior must be turned into constructive action on their part, and pointed out to them that the presence of uncoöperative individuals in a society was one they had already discussed in general terms and that they had realized then that punishment of the kind they wanted imposed had not solved the problems. He therefore suggested that it was up to them to study the

problem more fully and then work out a solution. Being confronted with the reality in this way of neurosis as a problem of their own group led to a reorientation of their outlook towards the problems of their own illness and an interest in the general morale.

Bion and Rickman were unable to continue these very important experiments of which they have given a brief account.* Following on this start, however, an attempt has been made by Main and Bridger to make a Military Psychiatric Hospital a field in which the neurotic patient can create new confidence in himself by learning to take part happily in the give and take of autonomous group activities through an increasing insight into, and toleration of, the psychological limitations both of himself and others. With this has been combined psychoanalytically based group psychotherapy evolved by Foulkes.

Civil Resettlement Units

When prisoners of war began to be repatriated their adjustment problems were investigated by Bion, working with officer repatriates, and Wilson with other ranks. It was found that practically all prisoners who had had a long period in captivity developed difficulties in adjustment to their new social field and it was clear that, unless something was done, these difficulties would create a serious problem when large scale repatriation occurred at the end of the war with Germany. There have now been established for these prisoners returning to civil life a number of Civil Resettlement Units run on principles worked out by Wilson, Trist and Rodger. In brief these Units constitute a transitional community in which the individual learns to change his adaptations to the captive community into attitudes which make for more successful tackling of the free conditions of civil life. Attendance at these Units is voluntary and the soldier may remain there up to three months. During his stay he is paid by the Army and his release from the Army does not become effective until the day he leaves the Unit. The Units are run by carefully selected military personnel and the living conditions at the Unit are made as attractive as possible. The only parade is the pay parade and from the start the soldier is introduced to the activities of civil life while still enjoying the security of the group. Frequent discussions of a free character are held in which all kinds of common problems can be ventilated. Visits to factories etc. are arranged and local representatives of

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*"Intra-Group Tensions in Therapy—Their Study as the Task of the Group." Bion and Rickman. *The Lancet*, Nov. 27th, 1943, page 678.

industry and of the Ministry of Labor give talks at the Units and answer questions. The soldier may even work at a factory for a time to sample for himself a particular job before he decides his future. Trained social workers, vocational psychologists, physicians and psychiatrists are available to him in the elucidation of his problems but the fundamental working principle is to create conditions so that he makes use of all the facilities spontaneously. It is as yet too soon to conceptualize the rich experience being gained in these Units in various problems in social psychology. Already, however, it seems that after the initial pleasure a phase follows in which the anxieties aroused by the imminence of freedom make the individual test out rather critically the sincerity and genuineness of the efforts of the Unit staff. There tends to be a somewhat agitated demand for control or discipline to be imposed by the staff but when that is refused he begins to accept the realities of his position for himself. There is then a great deal of constructive development unless the effects of his experience have reinforced previously established internal barriers to free social locomotion. In such cases the help of the Psychiatrist is usually sought. The experience in this type of Unit is not only valuable from the point of view of the repatriated soldier making his new adjustment but also in relation to the attitudes of the members of the group into which he is growing. A great deal is being learned about the anxieties and tensions created in all parties when a group is given conditions for free democratic development.

The account of some of the approaches to group problems has perforce been rather sketchy. Much fuller statements will be required to do justice to them. The authors would like to mention in conclusion that the treatment of group problems such as those described has been accompanied by a marked group development on the part of the psychiatrists and psychologists involved. It has therefore been difficult to attribute work to individuals for so many of the approaches have emerged from consideration of the problems *by* a group. Projects have tended to be handled by varying sub-groups yet there has remained a remarkable feeling for the group as a whole with the result that none of its members has tended to think of any particular contribution as his own though in fact, he may have played the leading part. The group, of course, has also had the invaluable contributions of many Army officers. As stated at the beginning it is hoped that fuller statements will be written later.

THE WARMING UP PROCESS OF AN AUDIENCE

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I. THE GROUP AND THE AGGREGATE

The group is not achieved through the mechanical addition of person to person, nor is the group simply a matter of persons being spatially close to one another. Persons belonging to the same profession do not necessarily constitute a group by virtue of the stated similarity. A structure of inter-personal relations exists among psychologically proximate individuals and this structure is not reducible to any elements, units, or other "bits of psychic stuff." When people engage in related activity or work toward a common goal in inter-awareness, they *create* a group. Furthermore, a group is a process and not a thing. It is possible to imagine a number of persons remaining in proximity who will not develop inter-relations, but no common activity nor goal can have been introduced. In such an instance it would be better to speak of an aggregate of persons. The initial problem of group psychotherapy is the development of a group out of an aggregate of persons. The word "group" tells us that each individual has emerged as a person with membership position in a network of interpersonal relations. Each person has a role relation to his fellows and a status in the hierarchy of roles in the interpersonal structure. Thus the individual of the aggregate becomes the person of the group, related to other persons by an activity or goal.

Aggregates exist as transition phenomena—one group is dissolving and in its stead another is organizing. This is generally equivalent to saying that the function common to the involved persons is changing. "Function" is an-other way of saying "structure" and not an opposing term. The function as a separate term identifies the activity over which the lines of organization es-tablish. The structure as a separate term identifies the positional aspects of real individuals (and not as is sometimes stated, abstract forces converging on abstract persons). Finally, a group is a structurofunctional process in time. These considerations lead us directly into the problem of the warming up process.

1. The inactive
   spectator.
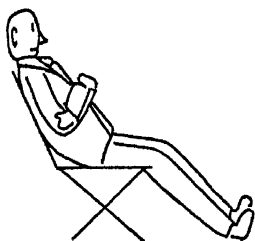
2. The active
   spectator.
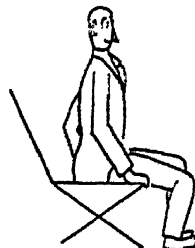
3. The participating
   spectator.
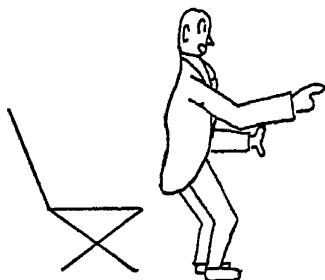
One of the important aspects of the psychodramatic session is the problem and process of warming up the inactive spectator to full and beneficial participation.

Warming up is always a two way affair in any session.

The reactive spectator becomes finally a participant actor, helping to organize the development of the session.

In group psychotherapy, the director is always aware of the degree and the stage of warming up in his group of patients. The degree indicates the efficacy of the technique in use. The stage indicates the condition of the disorder in terms of the amount of s- (spontaneity) factor readiness.

4. The participant actor.
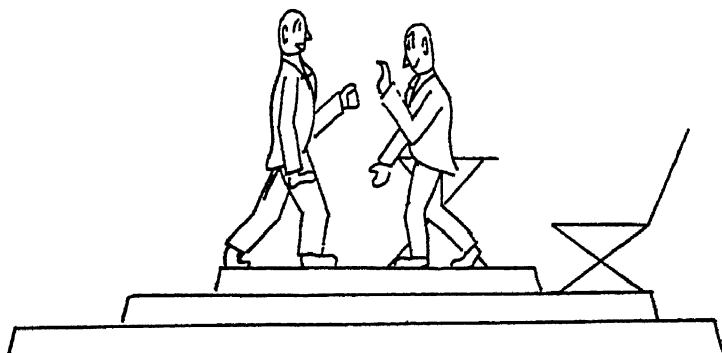
II. GROUP PSYCHOTHERAPY* AND THE WARMING UP PROCESS

The director of a typical psychodramatic session has as his initial problem the warming-up of his audience. This same problem is encountered

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*In this chapter some of the techniques are described which J. L. Moreno uses in psychodramatic sessions.

by the therapist who must develop a group out of an aggregate of patients.
Acting as demonstrator of techniques in sociometry, sociodrama, or psycho-
drama, the director is in an easier position. The topic arranged for the session
provides him with the solution. Around it as a guiding principle, he en-
courages the development of a group. Out of the way in which the inter-
personal relations structure between members of the audience, the themes
of activity arise. These themes are projected on to the stage through those
individuals who have warmed up to the degree of readiness (spontaneity)
required for impromptu presentation.

The usual techniques for the warming up of an audience are familiar.
The introductory talk is used most often for this purpose. As a sociometric
technique, the introductory talk is not so much an opportunity for the
speaker to express his convictions or to defend his evaluations as it is
the opportunity to awaken the interest of the audience, to arouse contro-
versial attitudes and private memories. This process of awakening develops
to the point where a number of the spectators are eager to present their
attitudes and memories on the stage. The group has begun formation.
According to the manner in which the speaker phrased his comments, these
individuals have begun to relate themselves either to the issues involved
in the comments or to the speaker. The director, in other words, may en-
courage the audience to organize with respect to him as a carrier of certain
viewpoints or with respect to the issues. Generally the latter procedure is
more effective from the point of view of the group. The former is an instance
of focussing transference upon the speaker.

By the end of the talk, each person in the audience should be awakened
to his individual viewpoint. Already there will be some in the audience who
are ready to activate their own attitudes by entering impromptu situations
on the stage. These first situations mark the completion of the warming up
of the audience and the start of the session proper. Henceforth the process
of activation furthers the structuring. The presentations of private view-
points on the stage delineate with progressive clarity the lines of organiza-
tion.

The participant actor (or auxiliary ego) is a powerful tool of the direc-
tor in accelerating the warming up. He aids the subject in the latter's
presentation and provides the director with the opportunity to interpolate
specific attitudes and behavior patterns. These may contrast with those of
the subject and so give them sharp relief. Again, they may stress and un-

derline the subject's actualized attitudes. Finally, the trained participant actor involves the subject so fully in the thematic development that deeper attitudes are aroused and brought into objective focus. Returning to the audience, this person has emerged as an individual to the rest of the members. With succeeding presentations, the roles of the audio-egos continue to be clarified in their relations to each other.

The director may not begin with an introductory talk however. Another approach which is more individual-centered has been used frequently. At random, he selects someone from the audience to join him upon the stage. In an informal, mutual interview, the director gains insight into the personal world of the subject. But, more important in the immediate sense, he discovers the subject's range of acquaintance with the other members of the audience. Using the topic of the session as the tool, he finds out what the subject's viewpoint is and how this viewpoint compares with those of his acquaintances in the audience. Thus the subject begins to define his own role relations to those other persons, with respect to the topic. This role-definition through implications tentatively outlines the roles of the others. As the subject warms up to the mutual interview, bringing out more detail, involving more issues, the strangers in the audience develop an awareness of their own attitudes. The spheres of role-relation widen and incorporate more and more persons in the audience until finally each one perceives his relations to the subject on the stage and to the subject's acquaintances. In a real sense, the acquaintance volume of each audio-ego has expanded to include these persons.

The mutual interview ends with the subject entering an impromptu situation which has grown out of the role-definitions. The participant actor may be selected from the director's staff or may come from the audience, depending upon the readiness of the individuals. In the total view of the session, the mutual interview holds the same position as does the introductory talk. It marks the end of the warming up of the audience. The members have become related. One advantage of the mutual interview over the introductory talk is that in the latter the director must be careful to call attention to the issues he has verbalized rather than to himself as a protagonist of certain attitudes. Another advantage is that the mutual interview maintains the issues as concretely located in a member of the audience rather than in the abstraction of the issues themselves. These advantages alone render the mutual interview more effective and more economical in a

time sense. An introductory talk incorrectly handled retards the development of the group as apart from the director. It may take considerable time for the audio-egos to discover their relations to each other rather than their relations, as separate persons, to the director. On the other hand, the expertly handled talk will be fuller in scope than the report of any one subject drawn from the audience. The specific needs of a situation determines which method is best suited and no rules are possible as yet.

The group psychotherapist is similarly confronted with the problem of encouraging the development of a group out of the aggregation of patients. But he has no ready solution in the form of a topic for the session. He must discover the principle of organization within the aggregate itself. This principle has to be at once natural to the involved patients and therapeutically useful. Conveniently, however, he can select the patients who are to go into the aggregate whereas the director of an educational demonstration accepts whoever comes to the session. This convenience can be used to set the scene for organization.

The therapist may decide to aggregate patients with similar syndromes. An audience of alcoholics is readily approached with the theme of initial addition to drink, for example. It is possible for the aggregate to develop into a group even where the syndromes are not related. Patients may be brought together because their case histories indicate similar "psychic" trauma or similar etiologies. It will be more difficult to encourage group organization at the outset with this arrangement, but it is a question for experiment whether or not such a procedure may enrich the individual patient's comprehension in the end. Obviously, the haphazard aggregate with which the director is faced is not advisable for the therapist.

The introductory talk is of less value and is more hazardous in group psychotherapy than it is in educational demonstration. To encourage the patients to develop transference to the therapist considerably limits group structure. Far preferable is it to encourage inter-relations among the audience members, for it is almost a certainty that individual transferences to the therapist will occur. Again, the therapeutic session initiates at a deeper level than the educational one, and for this the mutual interview is clearly superior. Work on the social level does not have to activate the recesses of personality as much as psychotherapy. The mutual interview goes further in familiarizing the patients with the impromptu process and gives a concrete psychological climate to the session. Finally, the mutual interview gets

down to work immediately, eliciting material for the first situations. The individual-centered approach of this technique opens up not only the acquaintance volume of the subject but also moves into his personal world or social atom. The relative importance of these two areas reverses: the educator is more interested in the acquaintance volume as a starter and works into the social atom later on; the therapist prefers to activate the personal world as soon as possible, using the facts of acquaintanceship as an audience-directed technique. These facts may become a discussion focus between situations. It is of greater importance to utilize the reports of the personal world as group structuring devices since they simultaneously function in the therapeutic process.

The importance of the auxiliary ego is impossible to over-evaluate. The entire process of group psychotherapy depends upon the skilled use of the auxiliary ego and upon that person's own resourcefulness and experience-range. The warming up process is an especially delicate procedure. It is familiar to us that patients readily identify with figures verbally presented to them. This mechanism is even more striking in group psychotherapy where the presented figure is a real person enacting attitudes and experiences similar to those of most of the audio-egos. The initiating impromptu situations must be directed so as to encourage each patient to develop his own readiness to activity. At the same time, mere audience-directed inveigling is time-consuming and doubtful in effectiveness. A frequent solution is for the therapist to begin with simple situations, having aspects common to all the patients, using the auxiliary ego as an extension of the subject's ego. As such an extension, the auxiliary ego concerns himself with the encouragement of the subject's projection and gently guides the subject into more personal expressions of his behavior patterns.

The similarities and differences between the educator's approach to the audience in a session of educational demonstration and the therapist's approach have been suggested in their broad outlines. The director faces a haphazard audience and encourages structuring along the lines suggested by the topic arranged for the session. He may start with an introductory talk or the mutual interview with a person from the audience. As either draws to its close, the general organization of role-relations has realized. The first impromptu situations mark the end of the warming up of the audience. From then on, the roles of those who have worked on the stage as subjects are enriched with detail. This detail stimulates similar enrichment in each
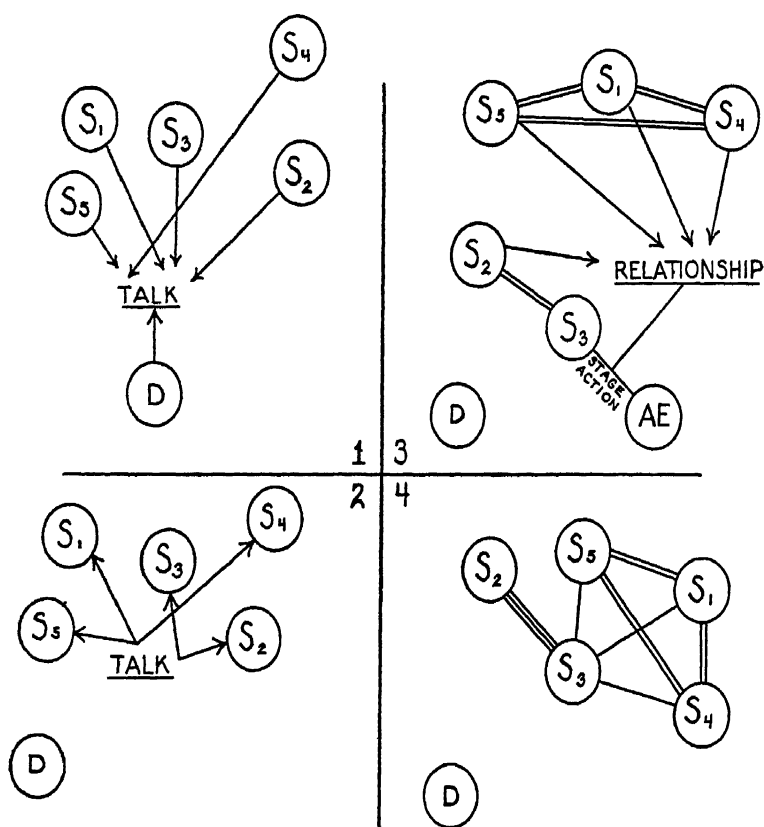
DIAGRAM II

S = Spectator
D = Director
This diagram portrays an audience in four stages of progressive interaction and integration (1, 2, 3, 4):

        (1)   amorphous stage
        (2)   stage of acquaintance
        (3)   action stage
        (4)   stage of mutual relations

audio-ego. The therapist faces an audience whose members have been se-lected in advance ,in accordance with the group structure the therapist plans to encourage. He will probably prefer to initiate the treatment process by the mutual interview because of its individual-centered nature. The opening up of the personal world or social atom provides the thematic material over which the structuring of interpersonal relations develops. Thus the therapist begins at a deeper level of investigation, encouraging role-relations with respect to more fundamental issues. Both the educator

and the therapist find the auxiliary ego extremely helpful, the former using him in the less profound version of participant actor.

III. CONCLUDING NOTE

In sociotherapy the social personality of the person is involved. It is the public individual in interaction. The viewpoint taken by the director of the session directs his attention toward the group as structure. A general catharsis is intended. In psychotherapy the single individual is in the focus of the director's attention. The subject's personal world of objects, somantic creations, and role-relations constitute the view. The catharsis must be thorough, effecting a reorganization of the structure of this personal world. The private individual in interaction is in the focus. Group psychotherapy combines these two approaches. A combination from the point of view of the individual cannot be effective. One individual added to the next is meaningless. The group is made the subject of treatment and through it, the individuals. This is meaningful and effective.

Whereas in sociotherapeutics the interpersonal relations shape at the social (public) level, in group psychotherapy these relations must locate more intimately, involving fundamental issues of the personal world. The common aspects of the personal world are brought into group awareness and each member comes to share the same personal world with his fellows. The treatment then works into the idiosyncratic features of each case, and rapid generalization of these features through discussion techniques, for example, maintains a heightened atmosphere of psychotherapy. The catharsis in action of each individual distributes, as it were, to the others along the lines of the network organized among them. These distinctions were not drawn in previous passages because they involve far more than the topic of the article, but they have a definite meaning in terms of the particular way in which the warming up process is to be handled.

MUSICAL METHODS

THE ORGANISM-AS-A-WHOLE AND MUSIC THERAPY

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William White's "organism-as-a-whole" concept is helpful in understanding the therapeutic properties of the fine arts. It conceives a human being as a compact entity, sealed by nature, time and habit—even if composed of many opposing tendencies. "Organism-as-a-whole" does not reject the idea of "mind and body," but relates them as inseparable and having a common purpose. The viewpoint organism-as-a-whole is particularly enlightening in dealing with nervous and mental patients.

Although the arts have never been seriously mobilized for therapeutic attacks as have herbs, chemicals, electricity and numerous other agents, yet they made themselves keenly felt in the field of mental hygiene and as useful social vitamins.

The arts, more than other agents, arouse the organism-as-a-whole, not only because of their aesthetic appeal, but because they accent human experience. As Dewey says: "In art as an experience, actuality and possibility, or ideality, the *new*, the *old*, objective material and personal response, the individual and universal, surface and depth, sense and meaning, are integrated in an experience in which they are transfigured from the significance that belongs to them when isolated in reflection." Art penetrates man's senses and arouses emotions, feelings, the glands and intellect. It affects his entire past, his rites, ceremonies, his religion, his morale and his conduct. The Greeks understood that art reflects the emotions and ideas associated with the chief institutions of social life. Plato's demand for censorship of poetry, music and drama shows how strongly they believed in the influence of the arts upon man.

Always in the vanguard of science, the arts foreshadow human progress, even in technical endeavor. A substantial number of discoveries and inventions were vaguely conceived in the fertile minds of poets and writers long before the blueprints were drawn. The idea of submarine and transatlantic aeroplane slumbered in the imagination of Jules Verne and in the

story of the "Magic Carpet." Science, which proceeds more slowly and cautiously needs the inspiration and prophetic spark of the arts.

Long before Sigmund Freud untangled some of the mysteries of the mind and conceived the conscious and sub-conscious, Goethe, Nietzsche and Hartmann with rare insight grasped its workings. Dr. Faust, the conscious, and Mephistopheles, the sub-conscious mind, portray the eternal struggle between the two. The influence of the arts upon man's life and emotions is no less effective than that contributed by the academic deliberations of Freud. By gratifying man's unconscious need for affection, for aggression and narcissism, they are, in their own way serving a "therapeutic" purpose. Moreno's dictum:—"A true therapeutic procedure cannot have less an objective than the whole of mankind," becomes more concrete if one thinks of the effects of the arts.

The arts not only please and enlighten but they assist in relieving emotional tension. In "Brothers Karamasov," Dostoyevski through Mitja not only relives his own patricidal impulses, but helps vicariously to alleviate similar impulses in the readers in whose bosoms such impulses may lie dormant. The introvert, Don Quixote, and the extrovert hypomanic, Sancho-Panza, foretold Kretshmer's constitutional types.

Music, even more than prose or drama, presents an opportunity for stifled emotions to find vent, by means of voluminous body rhythm and motion. Listening to Rimsky-Korsakov's "Ivan The Terrible," for instance, is bound to have some effect in relieving sadistic impulses, even if the listener may not be aware of the plot. And one can mourn the death of a dear friend with less grief listening to "Asa's Death" Mood music has the capacity to objectify personal sorrow; to shift it into "world sorrow" which is, of course, easier to bear. The music of Richard Wagner, who had himself been disappointed in love, provides an example of this. The groping, morbid, unsatisfied phrases, building towards tremendous climaxes which never arrive, represent extreme frustration, thus providing an outlet for those in similar situations. Also, happiness and gayety can be accented by mood music.

The selective action of the arts is the organism-as-a-whole and not that of a special tissue or organ as is the case with medicaments, viz. digitalis or pituitary extract, which affect the heart and water diuresis respectively. In whatever motive power the arts may reside—a product of the uncon-

scious, a suppressed sexuality, or an attempt to counteract the fear of nature's mysterious forces—they inspire, socialize and educate.

The arts have always served as a medium for bringing people together and uniting them. And of them all, there is no equal to music as a cementing force, a force which at once creates unity and intimacy, even in the most heterogeneous congregate. Racial and lingual barriers, differences in creed or education are easily surmounted by the musical message. One cannot hate the one with whom one is singing, provided the voices are modulated to blend. John Dewey's observation that "Art breaks through barriers that divide human beings and which are impermeable to ordinary association" is very applicable to music.

A given composition not only helps to sublimate the instincts of the composer, but serves a like purpose to the performer and to the listener. Each may be affected by the same composition in his own way and each may be benefited to a greater or lesser degree. A talented performer will deliver the original message of the composer, preserving its emotional content and meaning so that the listener will get the full impact of it.

Beethoven's statement, "Music is the mediator between the spiritual and sensual life" finds strong substantiation in clinical observation. The socialization of the sexual instinct is effected by means of music. Lower species of animals use brute force to do the work of procreation. There are female insects which devour the partner in the process of love-making. Others force coitus by superior strength. Pursuit and capture are gradually replaced by sexual advertisement, through rhythmic movements (the dance), sounds and colors. The evolution from killing during coitus, forcing coitus by superior strength, to luring and inducing it through rhythm and sound represents quite a progress. Thus the enlarged limbs with which certain species of crustacea seizes and holds the female, evolve into the chirping of the cricket, croak of the frog, the charming song of the nightingale, and finally, the crooning of a Sinatra. There is a deep meaning and strong social impact in music which no doubt emphasizes its therapeutic significance.

Sound is the principal medium by which most of the higher animals express and excite emotion. The male bird courting the female, reassures himself of his ability to procreate and thus further charges his sexual resources and generates pleasure. In many instances, the mating season alone,

even in the absence of the female, offers this biological reassurance when sounds are produced. Singing in courtship makes the goal appear nearer.

The same mechanism is operative in man and is highly significant. He, too, can socialize his sexual impulses through the dance, vocal chords or self-made instruments, thus providing emotional relief for himself and safeguarding the community from aggression.

Music, the greatest outlet for man's emotions, offers ample opportunity for the sexual instincts to exercise comparative freedom of action. The animal instincts, firmly saddled by social, moral and religious imperatives, find their way out into the open, peripherally, through rhythmical movements and emotional display. Music and the primitive form of it, the dance, are nearest to the natural means of sexual gratification.

The behaviour of human beings aroused by "swing" for instance, is suggestive of coitus. There is close contact, the embrace, the back and forth, the "swing" and final exaltation. So near and yet so far, that's the way of music's action. It furnishes atmosphere and excuse. The value of music to man is that it offers a "modus vivandi" to the two most bitter and irreconcilable antagonists, the brain and the spinal cord. This is the chief reason why music is welcomed and is readily accepted by the church, school and home.

Music signifies the principles of liberation in the practice of institutional psychiatry. Mental patients are in fear of and subject to restrictive treatments, often still necessary in overcrowded, understaffed institutions. The manner in which the patients are brought to the institution differs fundamentally from the customary procedures of admitting patients to other hospitals. A process of legal ostracism precedes commitment. The therapy that is offered to the mental patients still has the bad odor of the 17th, 18th and 19th century punishment and restraint. There are mechanical restraints, chemical restraints and hydriatic restraints. There is disguised punishment in the electric shock procedure. All these in addition to the over-powering force of the general mental hospital regime with its barred windows and locked doors; with its formalism and often unsympathetic attendants; with the monotony of institutional procedure where menus, the daily routine and practically all activities are regimented. The whole atmosphere tends to suppress rather than to free and expand. Traditions and the weight of organization, as well as public prejudice, make the task of healing doubly difficult.

Music, of all the dynamic arts, is capable of counteracting much of the fear and restraint inevitable in mental institutions. It disposes of therapeutic nihilism. Offering patients an opportunity to "abreact" through music is a great step toward emotional emancipation and build-up of the ego. It is amazing to watch mental patients singing and dancing in spite of the fact that their arms and legs are strapped. Obviously, under the influence of musical impact, the patients forget that they are in restraint. Listening to music, and especially singing, makes their minds feel free, just as the song throughout the dark pages of history has lessened the burden of socially, economically and politically chained people in their daily tasks.

The "Song of the Volga Boatman" provides a socialized way of overcoming life's exigencies by psychological means, even while tied to the oars. The Spirituals and Work Songs of the Southern Negroes made life endurable under very difficult circumstances. Songs like "Steal Away to Jesus" and "Swing Low Sweet Chariot" not only liberate the emotions and appease reality, but create hope for a better future. Folk music, both singing and playing, has a definite function in the practice of music therapy. It not only reacts on the collective musical consciousness of the race, but through association recalls happier memories. Its value should not be under-estimated. Boogie-woogie and jazz are certainly music of the people, and as such have definite value in mental rehabilitation of patients whose cultural level has never been raised any higher. The cultured man still retains his animal self and thus the jazz-brand of music may still affect him. To make a statement that such music is detrimental would indeed be very short-sighted. On the other hand, to expect to gain results through such media in treating patients who have been accustomed to a richer diet of Bach, Beethoven and Brahms would be equally careless.

The absence of family ties of institutionalized patients presents a problem which music helps to solve. Music provides a feeling of unity and belonging. Case after case of uncooperativeness has improved when musical activities were provided. Attendants inclined to be adverse to any procedures that might break the prescribed routine, are soon won over when they realize how music therapy lightens their own tasks. Indeed, the effect upon the attendants is as important a factor as the benefits to the patients, especially during these days of limited and over-worked personnel. The public from whose ranks mental patients are bound to come, feels more

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reassured knowing that the hospital also provides some of the high cultural values.

Lately, the group method of treating mental patients and the servicemen suffering from combat fatigue has become the choice method, because of the time saving and the social impact which it exercises. The "coherence" of a group depends upon several factors, chief among them a leader, a goal and emotional currents. A leader is not indispensable—a group can exist on a fratriarchal basis; a goal can be minimized or become unimportant by changing events. But an emotional current always flows where there is a congregate of people. *It is precisely music that makes this emotional flow mighty*. In a mental ward music is not only valuable as a vehicle to group therapy, but as an "appeaser" of the *status quo* of the hospital atmosphere, as a morale builder, as a source for individual emotional relief and as a medium of self-expression and ego aggrandisement. In group singing such factors as inspiration, self-discipline, solidarity and friendship are cultivated.

It becomes apparent that music plays an important part in the biological, sociological and cultural departments of life and that it is linked with propagation, survival, socialization, progress and aesthetics. Possessing such unusual ingredients, it is astonishing that music's powers have not been sufficiently utilized in a practical way.

Let's hope, therefore, that in the future the physician, the psychiatrist, and the music educator will unite in this common cause and bring to mankind all the benefits that reside so plentifully in music.

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MUSIC AS A GROUP THERAPEUTIC AGENT IN THE TREATMENT OF CONVALESCENTS*

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A year ago, authorized experimental work in Music Therapy was initiated, through the Office of the Air Surgeon, at the Fort Logan AAF Convalescent Hospital, one of ten convalescent centers under the Personnel Distribution Command. As a PDC Special Project this work continued under way in one of the hospital buildings which had been converted for this purpose. With the help of a capable staff of eight highly specialized enlisted men, the cooperation of the entire Education Branch and the Fort Logan Band, activities were carried on to aid overseas returnees and continental men to rehabilitate themselves mentally, physically and spiritually.

The Music Therapy Program was set up in such a way as to afford music instruction on any instrument. It also offered diversional opportunities through the media of the hospital public address system; by supplying musical instruments for practice and instruction purposes; by making on-the-spot transcribed recordings either in the Music Therapy building or at a patient's bedside. There were jam-sessions, song-fests, letters made on recordings and sent overseas or to folks at home. Some "eager-beavers" made improvised musical instruments and used them for their own entertainment and enjoyment.

PDC Headquarters sent an expert, the inventor of the "Xylette" (two and one-third octave, 15-pound, miniature piano), to each one of the PDC convalescent centers for thirty days to demonstrate how to build the miniature pianos. These portable pianos were constructed mainly of hard wood and salvaged parts from the hydraulic system tubing of a B-17. It was hard to believe or give credence to the fact that music could be played on aluminum tubing out of an airplane. The results were truly surprising! The Education Branch opened the facilities of its Tinker Shop and taught the ambulatory convalescents how to make the parts and assemble the miniature pianos. We found it took an average of fifty-two hours for a convalescent to complete one instrument. There too, in the Education Branch,

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*This paper has been cleared through the authorities at Fort Logan.

the Woodworking Shop was ready to help ambulatory patients who brought in damaged wooden musical instruments, in making any possible repairs.

While at Fort Logan, this teacher and inventor, under the direction of PDC, instructed a group of musicians in the best use of the AAF Training Manual number 29, called "Sit Down and Play." This manual had been written especially for use in the Convalescent Training Program by the person who was sent out by PDC to put the last touches on the various instructors' techniques. Nothing was done haphazardly in the PDC centers. Short cut, but approved, methods of teaching were promoted by the Music Section and the Music Therapy Project. It was not uncommon to have three men sitting at three pianos, with canes or crutches propped alongside, with their tongues pushing out one side of their mouth, plinking out "Don't Fence Me In." Within one week of their starting lessons they could play tunes that other patients could not only recognize but could stay and applaud.

After the Music Therapy Project's modest debut at Fort Logan with a xylophone of empty wine bottles filled at varied levels with water, a set of improvised drums augmented by a snare and bass drum; a set of chimes built of aviation ball-bearing rings strung on a wooden frame . . . and . . . a small group of patients, attendance increased daily.

The first group was made up of the "jammingest gates" in the business. They beat out rhythms all day long. All of them had been very sick, all of them were continental men and none of them knew how to read music. Almost every man who entered the music building did so voluntarily, looking for that intangible quantity called music. Playing it was an emotional expression and an outlet for pent-up feelings. Hearing it was a satisfaction, fulfilling a need with a diversional relaxation . . . this was so because Music Therapy functioned on a voluntary basis. No one HAD to take it. To these men this music business was strictly "groovy," strictly "hot," and as we couldn't help seeing . . . strictly diversional. Diversion is a therapy itself, Without it people go crazy. Music is a part of Man . . . born in him. Down through the centuries it has never been obliterated or stopped by war, greed or famine, cash or politics. In this respect it is a stronger power than Man himself . . . and yet, without him, it cannot fulfill itself.

The next group of patients, comprised mainly of orthopedic cases from the physiotherapy ward, straggled in from time to time, and began to join the first or "jive" group. Interest began to swing toward building

improvised musical instruments and tinkering with the hospital public address system.

Under the skillful manipulation of the NCOs of the Music Therapy Project, a broadcasting studio was built and the equipment which is part of every PDC installation, was housed and presented in such a manner as to look like a reasonable facsimile of a commercial network radio studio. The entire staff was justly proud of its end-result and christened the studio by adopting the call-letters "FLCH" taken from the words: Fort Logan Convalescent Hospital. The therapy value here lay in the point that the greatest proportion of materials used in building and operating the P.A. system had been dug out of waste materials and had been utilized mostly by patient-personnel.

This meant economy, accomplishment, initiative and both mental and physical exercise and stimulation for each participant. Further, these men were using the knowledge they had learned at AAF specialized schools. They didn't feel that working in the Music Therapy Project was "sissified" because they handled familiar war materials which took skill to work with, and which were a medium for building self-confidence. These activities diverted the recovering man's mind from himself and turned the subjective outlook to that of helping others less fortunate or, as we might put it, to a more objective trend.

More and more the personnel of the Music Therapy Project was trying to broaden the patients' perspective and rehabilitate them socially as well as physically. Three factors were necessary to "bring back" a returnee or a sick man whose social-sensitivity had suffered trauma through war experiences. These factors which we believed to be most important were three perspectives or qualities: 1) the mental, 2) the physical, 3) the spiritual. These three integral parts were needed to remake a wholesome whole.

All this time the Music Therapy Project, now a part of the recently organized Music Section, was working with the help of the chiefs of the specialized medical services in the hospital. These men were the army doctors in charge of Orthopedics and Physiotherapy, Psychiatry, General Medicine and Surgery. Under these men it received suggestions for proceeding and introductions to patients. The Chief of Psychiatry was appointed medical head of Music Therapy.

Meanwhile, back at the project building, music instruction, lessons in announcing over Station FLCH and technical use of the controls and

radio techniques were being taught to convalescents who dropped in casually and stayed to learn. The fascination of talking to your buddies over a microphone and personalizing the P.A. system for those who listened in bed in the surgery, physio and isolated wards never ceased to intrigue returnees who had been radio men, bombardiers, tail and waist gunners, navigators, pilots and mechanics or engineers. But more important, these same men who had been bed patients themselves were "dishing it out" for the fun and entertainment of men now confined to their beds.

We realized there was our listening audience to consider as well as our performers, instructors and pupils. How could we best reach them? What types of music would have the largest appeal? What music would help them most? Some of our staff canvassed the hospital wards to engage in social conversation those patients who were bedfast; another made posters, program slips, personal request blanks for filling in and surveying patients' choice, and originated contests to stimulate through enthusiasm the participation of these patients who could not leave their wards. Volume controls were installed on all speakers throughout the wards so that patients being given treatments for combat fatigue would not be disturbed by overstrength volume of broadcasts and yet, other patients could continue listening to music, variety programs, sports, news and their fellow patients.

The installation and maintenance of equipment·in the wards and of the P.A. system was looked after chiefly by an NCO with civilian radio and electrical experience. The supervision of the patient announcers and technicians was handled by an NCO who had been one of the first patients of the Convalescent Hospital at Fort Logan. Another NCO, also a patient originally, took over all promotional ward work and devised record systems covering hours of patient participation, charts, graphs and all pertinent factors effecting the work of the project. The other NCOs were instructors in music. Each had been a successful teacher and musician with well recognized professional careers back in that good old civilian era long before anyone knew there would be another war to win.

Now there are two buildings where instruction is given in music. There is a record library totalling some 6,000 records of which 1,000 are in a mobile state, the remaining 5,000 serve as a source of supply to dayrooms, wards with phonographs, or to fellows who are seeking to complete personal collections of "platters." There is a music appreciation room equipped with an electric record-player and another carefully selected library of albums

of classics, both concert and popular. There is the Band Loft where a convalescent pupil can join a jam-session or practice with other members of the Fort Logan Band . . . or where he can discuss the arrangement of any music he might compose and where, if it is a good composition, he will have a chance of hearing the band play it. This is something few of us can buy, even though we offer to pay for the opportunity in good hard cash.

Quite recently, under the direction of the Education Branch, new horizons have been viewed through the joint cooperation of the education program and the music and sound program. We have started making transcriptions of the voices of convalescents engaged in activities of the General Speech course offered by the Education Branch. These transcriptions will become an active, audible file by which the convalescent can gauge his improvement and progress and which will serve as "confidence in his pocket" should this course be instrumental in overcoming a possible speech impediment or defect due to nerves. Later these speech course enrollees will be given training at the Station FLCH studio in the use of a microphone and in radio dramatics.

At mealtimes and for a period thereafter, smooth, relaxing, familiar music is played over the ward network of Station FLCH. We have received just one complaint from a patient and that in his own words was: "That's a —— of a program you've got on!" When we inquired what was wrong with it, he retorted: ——, everyone's asleep alla time now and I can't find me a pinochle partner." So we conclude that on a basis of common sense, if a person can relax while eating he will benefit from what he eats; that he will convalesce more quickly. If he can be induced to relax enough to sleep restfully, he will also be aided toward a swifter and more complete convalescence. It is to these ends we apply music as a therapy.

All these factors have been used and given a chance to be tried out by the commanding officers in PDC Headquarters, the Office of the Air Surgeon, and most immediately, the Commanding Officer of Fort Logan and the Fort Logan Convalescent Hospital, and all the "men in charge" at Fort Logan. The real men in charge are the inner-men within the convalescent patients themselves and it is the other "men in charge" who are helping give them their chance for recovery and re-discovery of all they had before the war.

NOTE ON PSYCHOMUSIC AND MUSICAL GROUP PSYCHOTHERAPY

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INTRODUCTION

From the very first J. L. Moreno has in his writings dedicated himself to the necessity of a maximum study and use of the spontaneity factor in all the arts. The drama of life includes, among other things, conversation, thought, work, play, dance and music. Moreno has at various times devoted himself to the need and possibility of gaining the utmost use and understanding of these in terms of the spontaneity factor. His investigation of the art of music, his impromptu orchestras, his psychomusic and musical group psychotherapy experiments have been a most penetrating example of the wider sphere of his endeavor. A re-examination of some of Moreno's findings in the music field is the subject of this paper.

Because it is a poignant and a fluid medium that contains a minimum of association with the routine patterns of our day-to-day life, and because it is so varied and universal in its appeal, music is undoubtedly a unique and important therapeutic agent.

To date, the larger field of music therapy has been devoted to auditory or passive participation by the subject. Patients attend live or recorded concerts and find catharsis in the association, atmosphere, or relaxation which they derive from the music. Accomplishments in this field, especially in Army psychiatric hospitals in the last several years, have been noteworthy.

Passive music therapy, however, has persistently posed one primary difficulty. It has been found invariably among all people, patients as well as non-patients, that there exists a certain group that have a partial if not an absolute apathy to music. These are the people whose response is one of disinterest, and even drowsiness and boredom. Also, even where there *is* a definite taste for music, quite often its effect on the psycho-physio system of the patient has been too superficial to provide any real therapy. A richer, more moving experience has been desired.

RELATION OF MUSIC TO HUMAN MIND

Before probing this phenomenon, it is well to define the term "music", and to discover what there is about it that interests the human mind in

the first place. Music, acoustically is nothing more than sound frequency pattern, combined with rhythmic pattern. There are other correlaries such as tone quality (actually determined by overtone frequency), scale formations that have been founded in habit and tradition, and volume or intensity. However, the basic component of music, to which these may only be added, is the group of sequence of rhythmic (rhythms) tonal frequencies (pitches).

That these rhythm-pitch patterns do have a profound effect on some of us, that they do indicate that the composer that chose to set them to paper did express a "gay" or a "disturbed" or a "gracious" emotion at the time that they were conceived, obviously must be due to some association between these patterns and the human mind. The answer is to be found in the fact that the organism also passes through a series of rhythm-pitch patterns as it travels through the emotional gamut of its existence, and that the passages played by one or a group of instruments bring these to mind. (The extent to which this association is *exactly identical* with the composer's original state of being is immaterial. A very substantial portion of the composer's original conception is inevitably present.) The pitch fluctuation of our bodies is indicated by a greater or lesser tension in the entire organism, or in any separate part of it, as for instance, changes in our vocal pitch (caused by greater or lesser tension applied to the vocal chords), clenching or relaxation of the fists, focusing of the eyes, holding of the breath, and a host of other symptoms all related to changes in emotional states. The rhythmic fluctuation of our mobile movements, breathing, heartbeat, rate of thought, etc., represent the rhythmic pattern in our mood or emotional state. Of course, in somewhat the same manner that a painting represents a scene, or a word represents an object, the stimulation of emotion by the music media is essentially symbolized.

The fact that certain individuals are entirely unresponsive to music is due, in the main, to the inability of the individual to make the necessary association between personal frequency patterns and those to be found in the music. Furthermore, those that are capable of only a limited response to the media, per se are limited in the extent to which they are capable of making the association. The background of such limited association is diverse. Many habitually fail to take the time or trouble, or are traditionally uninterested, or find other pursuits more to their liking. Also in our society, being sensitive to more exalted or complex emotions is in a sense an expensive luxury. We develop an apathy to anything that is *not* accepted by the greater majority of people, because in the business of life one must

hesitate to move out of widely accepted cultural atoms, or face the likelihood of being ostracized from certain professional and social spheres.

ACTIVE MUSIC THERAPY WITH CONVENTIONAL MUSIC FORMS

A genuine sensitivity to music may be gained or amplified if the subject indulges actively in music making. Singing, playing an instrument, chorus singing, rhythm bands, and even dancing to music are types of active music therapy. The physical, mental and emotional mechanism are thrown into a kind of rhythmic frequency activity that to a considerable extent is similar to the pattern of the music. And in so doing the emotional association becomes intensely apparent. Especially for the person who is performing or interpreting it, music moves quickly to the innermost being. In addition to hearing the suggested mood inherent in the piece itself, it offers a sustained and expanding activity sequence which may provide an effectual catharsis.

However, active music therapy, as outlined above, is unfortunately a very limited psychotherapeutic medium. The mechanical technique involved in bringing an individual or a group to "sound" often exacts so much in hard, dull practise as to make the result hardly worth the effort. There is no such thing as music in ten easy lessons. It is an arduous study, best begun in childhood, which requires years of work for even the most elementary accomplishment. After a year of steady work at the piano, for instance, a subject, one with good hands and a good ear, may just be ready to play nursery-rhyme tunes with some proficiency. And except for children, this is not very rewarding. Even in an amateur chorus, the grief that a subject encounters is so painful as to afford little or no time for personal emotional release. Amateur choruses have a notorious mortality rate though they often start with enthusiasm. Making music requires extreme dexterity. It can be compared to the process of learning to talk, though perhaps it is harder, because we may talk everywhere and at any time. In addition to the musical alphabet it is necessary to train the fingers and the ear in the use of instruments far more variable and complex than even the most complicated lathe from the standpoint of the human element involved. This requires an automatic motor activity, in an infinite number of variations, which is almost without precedent in any endeavor. In his "Creativity and Cultural Conserves—With Special Reference to Musical Expression",[1] J. L. Moreno has made a comprehensive study of the

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[1] See "Creativity and Cultural Conserves—With Special Reference to Musical Expression" in *Sociometry*, A Journal of Inter-Personal Relations, Vol. 2, No. 2.

infinite difficulty which is to be found in the relationship between the musician, or would be musician, and his instrumental music making.

Another major difficulty has been pointed out by Moreno repeatedly.[2] It is the incessant stifling effect of the cultural conserve that is inevitably present in the music, and never permits it to become a real vehicle of spontaneous self expression. The catharsis may be remote or even entirely non-existent in terms of the subject.[3]

It is apparent, then, that two primary difficulties must be overcome in order to gain the fullest benefit from music therapy. *First*, the rhythmic frequency association must be sufficiently strong and active to allow the subject to project himself far enough into the full meaning of the music to allow for a rewarding catharsis; hence the need for some kind of active music therapy. And *secondly*, the experience must not be dulled or over-weighted by either an inadequate technical prerequisite, or an overdose of foreign conserve element. It is further apparent, that such a music expression is possible only if the subject is permitted to create music entirely within his physical or technical range and within his cultural atom. Just as we cannot expect individuals partaking in the psychodrama to issue forth with lines that contain the cultural conserve of a passage from Shakespeare or Schiller, or to possess the dramatic technique of Barrymore or Duse, we can hardly expect that an on-the-spot music activity initiated by the subject, shall in any way resemble Beethoven or Gershwin or shall be executed with even a remote resemblance to the music produced by Heifetz or Pons. It must also be remembered that a subject who has no knowledge whatsoever of music has only himself, his body and his voice with which to create music, or what Moreno has called psychomusic.[4] And finally, though we do have a technical and even a conserve structure around which to build a spontaneous drama (psychodrama) in the speech intercommunication begun in earliest childhood, almost non-existent use of the music medium precludes a type of music[5] which is very radically different from that which we have been accustomed to use in therapy work.

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[2]*Ibid.*

[3]". . . the warming-up process in a spontaneity test differs fundamentally from the warming-up process in a musical conserve performance. The one is autonomous, at least in the moment of production; the other presupposes a successful adjustment to any synthesis of different egos and minds." *Ibid.*, p. 16.

[4]See "Creativity and Cultural Conserves—With Special Reference to Musical Expression" in *Sociometry*, A Journal of Inter-Personal Relations, Vol. 2, No. 2, p. 23.

[5]Chapter on "Psychomusic" in *Psychodrama*, Collected Papers, Vol. I, Beacon House, New York.

DANCE METHODS

RHYTHM IN MOVEMENT AS USED IN SAINT ELIZABETH'S HOSPITAL

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There is a tendency on the part of certain patients in a mental hospital to remain motionless and mute for long periods of time, or to move about restlessly and avoiding contact with other people. Rarely, when left to themselves, do they gather for group activities. One method used at St. Elizabeth's Hospital for the encouragement of group activity is through classes in rhythmic movement.

The writer of this article was asked to try an experimental class in dance rhythm with a group of women patients in July in 1943, under the auspices of the American Red Cross which conducts an extensive but atypical recreation program at the hospital under the direction of the medical staff. Her previous experience in correcting behavior patterns of children who were anti-social, and in aiding adults with special personality problems, not sufficiently pronounced to need psychiatric care, together with several years of training at the Denishawn School of the Dance and as a member of their concert company and teaching staff, furnished a background for the use of dance movement as a medium for group activity with people not pre-disposed to cooperative action with each other.

During the past three years the number of classes has grown so that they now cover a large part of the hospital. Many forms of dance are used on both men's and women's wards. They are graded according to the degree of illness or convalescence of the patients rather than on the perfection of technique achieved by the individuals in a class. A patient starts in some class when he first arrives at the hospital, whether he is over-active or confused, catatonic or depressed, and he may continue in successive classes until he leaves here.

At first, only those movements which can be understood, by visual presentation or the sense or touch are asked of him. Later through gradual steps, he becomes able to participate in a formal class in which stress is laid upon posture, efficiency of action and a conscious group feeling.

On the women's wards and on the wards where catatonic male patients

are cared for, rhythmic exercise is used, but on the balance of the men's wards the accent is placed upon social dancing. It has been found that many of the men patients at this hospital feel ill at ease on the ballroom floor, and consequently fail to take an active part in large gatherings of this nature. Through the class for the practice of ballroom steps, and the social hours with men too sick to leave their wards, many patients have gained confidence in meeting new people socially by the time they progress to open wards.

All classes, whatever the degree of illness of the patients in that particular ward, are conducted in a circular formation. Hands can be held around a circle, and a group unity achieved with patients who are too confused to remain attentive without the support of the group. It is possible in this formation to hold together as many as twenty-five catatonic patients. In this group they will do rhythmic exercises together—swings or arms and legs, stretching and limbering movements, bending and twisting actions, and even jumps and trots. These people will stay together while hands are held around a circle but will scatter into the far corners of the room to resume their static postures as soon as hands are dropped.

On an over-active ward, group rhythm in a circle is the only form which will enable the patients to feel free to join the activity for the few minutes that they are able to stay with a group in the midst of their own rapid, restless dance patternings. The circle often seems to act as a magnet, drawing them toward it, when they are too absorbed to speak or to join a formal class if they were asked to do so. This seems to be a satisfying grouping to the patients themselves, for they will form the circle for themselves, even when they are very confused, if the group leader fails to do so at the expected moment. While, on a convalescent ward, they will already have grouped into this formation before the dance director joins them.

By using a method of holding the patients together long enough to achieve a group rhythm, they are able to move about the room or to stretch long-unused muscles and gain a purely physical reaction of loss of tension with a definite improvement in body posture and co-ordination, no matter how confused and disturbed they may be emotionally. A growing self-confidence and ease of physical action keeps pace with their convalescence from their emotional disturbances. As the doctors prepare them to meet people more easily, they have acquired better equipment with which to do so. Poise and a lack of individual self-consciousness has many times been demonstrated by the convalescent patients at the hospital by the ease with

which they have taken part in style shows and demonstration classes for large audiences.

The dance director who expects to stimulate strong, simplified but unified movement in confused, restless, mute or motionless patients must be willing to be flexible in her approach, and have acquired a technique to meet their varying moods, in other words, play the role of "auxiliary-ego" at all times in her contact with mental patients. The mute drama of the dance may at any point develop into a psychodrama.

It is essential that when a session starts on a ward, where excited action is in progress, that the leader meet this with movements of equal force. In contrast when she enters a ward where the patients are almost totally lacking in the initiative necessary to move about or talk, she must be able to speak and move as quietly as the occupants of this ward. From these widely separated extremes the muscular action of the patients is carried by means of infinite varieties of group rhythms, to a mean degree of activity, and a quiet ward is left with movement that is pleasant but not too rapid, while an over-active group will have been led to a few minutes of quiet.

In doing this, sensitivity to action initiated by members of the class is an essential and in this way the form of the sessions does not grow into a rigid pattern, but can support and aid the patients in the group.

Not only must the leader be in sympathetic union with the moods of the patients, but the music used must also be in their own tempo and the color of the tones be those with which they are compatible. Whether an assistant plays a piano or gramophone recordings, this holds true. Again as with the rhythmic action and the approach of the dance leader, the music starts rapidly and loudly on an active ward, or softly and with no distraction on a depressed ward, and from these points it moves toward music that is strong rhythmically but not exciting. On the wards where catatonic patients are in the majority, men who have shown no inclination to talk, will sing as they walk in rhythm together to such songs as "I've been working on the railroad", and "Tavern in the Town" and afterwards gather around the piano and to sway together and sing songs of Stephen Foster. On the post-shock ward, men who are just coming out of the coma will sit up in bed with a smile as the songs of our folk culture are played and sung. Movement about the room, physical action in harmony with a group, and relaxation of tension are the aims of rhythm in movement as used at Saint Elizabeth's Hospital, rather than technical achievement as at a dance school.

MOTION PICTURE METHODS

THERAPEUTIC FILMS AND GROUP PSYCHOTHERAPY*

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The group psychotherapy program (1, 2, 3), which has been developed by the Medical Department, U. S. Navy, during this war, has had as one of its projects the problem of brief, large-scale communication of psychiatric ideas and attitudes and principles. Aside from the very obvious non-medical applications of these techniques (which are essentially those of education and training), it is believed that these techniques, fully developed, authenticated and amplified, are the crux of the pressing problems which confront post-war psychiatry (4, 5).

The benefits of psychiatric counsel and guidance both prophylactic and therapeutic have been restricted to relatively few persons. Not only has the lack of trained therapists imposed a very real limitation on the dissemination of psychiatric knowledge, but more important the semantic difficulties created by the often painful, verbal formulation of psychodynamics have added their imponderable bulk to the mass of existing emotional resistance to the acceptance of psychiatric doctrine. It is generally agreed that the techniques which have been developed to overcome these barriers on the whole are inadequate, particularly so when they are applied to the enormous therapeutic task presented by tens of thousands of patients.

Granted that brief treatment techniques which utilize the group approach are the best tactics for a large-scale attack, it appears reasonable to suppose that the use of audio-visual aids can set the stage by quickly creating a receptive emotional tone. In turn this psychological "set" is conducive to the elaboration of a wide range of appropriate patterns of adaptive and projective behavior in the patient-audience. This was the hypothesis which prompted the Bureau of Medicine and Surgery in 1943 to undertake the production of a series of motion pictures for use in the psychiatric treatment program. Thus far eight films (6) have been produced and distributed

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*The opinions expressed herein are the personal ones of the author and are not to be construed as necessarily indicative of the official opinion or policy of the Navy Department.

with the technical cooperation of the Training Films and Motion Picture Branch of the Bureau of Aeronautics. Several immediate uses were intended for these films. Primarily, they were made to serve as a supplement to the established group psychotherapy program which operates in the general and special Naval hospitals. In addition, they have been used as training adjuncts in conjunction with other special psychiatric training films for nurses, hospital corpsmen, and medical officers. Third, they have use as training aids in a prophylactic and educational curriculum for the instruction of non-psychiatrists, both line and medical officers. Finally, for a strictly limited experimental purpose, a few have been used as projective diagnostic and screening tests in a manner similar to Murray's thematic apperception and Rorschach's ink blot tests.

There is an old Chinese proverb: "Hundreds heard not like one see," which in essence states the *raison d'etre* of training films. Their implications for psychiatric educational purposes are manifold. The imaginative use of the camera can dynamically recreate the background, setting and formulation of typical individual and group problems. In this way the *generic* bases of motivation, attitude formation and behavior can be presented strikingly to many groups of persons. Moreover, this presentation can be succinct and validated for standardized usefulness on a larger series of patients than can any comparably controlled clinical psychiatric procedure. The drama and dynamics of intra and inter-personal relationships lend themselves to cinematic portrayal with a realistic flexibility which has very few limitations. Time, place and person can be treated graphically to illustrate and simplify the complexity of psychodynamics. The use of words, music and sound, and even color,* can provoke and guide trains of associations to the end that individual patients and groups are emotionally accessible. All that is then required for constructive action is the catalytic ferment of a social setting which will translate private attitudes and personal motivations into group participation and behavior. The clinician is provided with a therapeutic instrument which can enrich his role. The spade work having been done, he is free to deal with the nuances and shades of individual difference which characterize the *specific* bases of his patients' problems.

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*Auroratone films have been used with psychotic patients for this purpose (personal communication: 2nd Lieut. Elias Katz, A.G.D., Crile General Hospital).

The design and production of therapeutic films is tedious, time-consuming and costly. They require the combined efforts of a team of specialists—writers, artists, and production men, directors, photographers, sound men, actors, and the host of technical assistants who are required for the making of good motion pictures.

A therapeutic film (7) has to be conceived and produced in a manner quite different from the usual recreational or entertainment film. This is necessary to obtain the desired emotional response. The patient-audience has to be conditioned, so to speak, to the point where the group discussion which follows will be psychiatrically profitable. Further, the film must have an intrinsic teaching value; its facts have to be presented in such a manner that with the audience's personal experience as a background, the psychotherapy which precedes and follows, makes them acceptable as self-evident truths (6).

It is essential at the outset to recognize that at best, the therapeutic film is only an adjunct and a supplement to psychotherapy. The therapeutic film has to have the capacity to provoke an emotional reliving of personal experience. In order to accomplish this successfully, the theme has to have generic validity and a capacity to stimulate the audience to specify in personal terms their response. The sequence of events has to be presented synoptically. Literal chronology and factual detailing should be avoided; by innuendo and implications the confusing, the irrelevant, and the inessential can be subsumed in a backdrop of action. Camera, editing and cutting techniques can be utilized to highlight important events. The use of wipes, dissolves, insets, flashbacks and recapitulation can link the chain of cause and effect relationships. The sound track is capable of being used with the same kind of elasticity. Of equal importance is the timing of the film showing. A good therapeutic film asks questions; therefore, ample allowance in the therapeutic session which follows has to be made for the expression it evokes.

The most important cog in the production is the technical adviser. The possibility of inadvertent errors in the preparation of such potent psychological tools requires his constant close association and cooperation. His advice is necessary not only in the preparation of the script and the actual filming of the picture, but also in the final stages of cutting and editing and the recording of the sound track. There are many production details which have to be planned carefully in compounding the balanced prescription of a

psychiatric treatment film. Finally, not an inconsiderable item is the cost, which for a standard black and white live-action film commercially made, can average ten to twenty thousand dollars a reel. Full color pictures and animation are more expensive. By and large, it is these factors which to date have prohibited the wide-scale production and distribution of psychiatric films.

At the outset of the project under consideration, it was determined that an important aspect of the use of films was concerned with the compilation of various data on the indications and contra-indications for the use of therapeutic films. It was decided that their use by the Bureau of Medicine and Surgery would be restricted to selected patient groups; hence in much the same way that various other activities in the daily program in Naval hospitals are medically prescribed, the use of the psychiatric films has been subject to the same limitations.

Direct observation of the group, individual personal interview, and a questionnaire poll have been used to gauge and control audience-reaction so as to estimate the effect and potency of this therapeutic tool (7). Similarly, experiments have been conducted to determine the usefulness of infrared audience photography as well as sound recordings of the group discussions and comments which follow the film presentation. It was the purpose to obtain both subjective and objective documentation of individual and group response to motion pictures, and in that way to establish a scientific, over-all frame of reference.

In keeping with this, the manner in which each film presents its problem has been carefully controlled and purposely varied so that ultimately, if a sufficient number of possible permutations of techniques are utilized, it will be possible to determine the psychiatric limitations and applications of each. In this regard, animation, live action, the use of a visible narrator and off-screen narration, as well as the use of the story itself (intrinsic narration), have been used in the script preparation. Thus, a number of fundamental questions which arose concerning the theoretical and practical use of films have been partly resolved by the use of the personal interview and the opinion questionnaire. An illustration is available with regard to the film entitled "Introduction to Combat Fatigue."

The technique of story presentation in this film employs the device of a visible narrator—a medical officer—who presents, comments on, and analyzes the subject. There is no film title, and the lead contains none of

the usual credit references. The film opens abruptly on the doctor in his office in a Naval hospital. The familiar introductory musical score is missing, and the sound track throughout the film is recorded in such a manner as to mute battle sounds. The doctor addresses the audience in an easy, familiar way introducing the subject with a few descriptive remarks on fear in combat. The basic theme of the film is fear—its nature and manner of appearance, its usefulness and inutility, as illustrated by the events in the life of Corporal Ben Edwards, U. S. Marine Corps, a patient in that hospital. By the use of a running commentary, which objectively analyzes Edwards and his buddies' reactions to the anticipation and actual stress of establishing and securing a beach head in jungle warfare, a sketch of the natural history of combat fatigue in field troops is presented. Close-up shots of a cat's reaction to the nearby presence of a dog are shown as an example of a psychosomatic response to fear. This response is called in familiar military language "Condition Red." The first few hundred feet of film are used to establish the concept of the normality of psychological, physical, and environmental stimuli leading to an appropriate total body response. Gradually the pathological working of the fundamentally beneficial response is unfolded by a series of dissolves. In all there are 113 scenes in the picture. A summary of Edwards' present illness is presented by the following sequences:

1. Troop transport trip to the staging area; showing Edwards and the other men each tense in his own way in anticipation of combat.
2. The landing operation which utilizes selected combat footage and shows beach landing against light opposition, preliminary infiltration tactics, the digging of fox holes, the precautions used against snipers and air raids—emphasis is placed on the provocative factors of continual alerts, disturbed sleep, rain, cold food, etc., etc.
3. The climax occurs during a forward maneuver in which Hal, Edwards' buddy, is killed; Edwards' immediate reaction to this is shown.
4. There follows a series of shots of Edwards during the next few weeks during which time he exhibits irritability, startle response, restlessness, insomnia, culminating in his random firing at an imaginary Jap while on night patrol, which ultimately lands him in a field hospital.
5. Edwards being admitted to the sick list, interview by the doctor who points up the significant psychiatric symptomatology in the welter of symptoms and behavior which Edwards presents, and establishes the diagnosis of Combat Fatigue.
6. The narrator, Edwards' present doctor in a continental hospital,

recapitulates and analyzes the symptoms Edwards now displays, presumably some weeks later.

7.   The final series of scenes shows the hospital group therapy program synoptically as it centers around Edwards.

This film has had a wide distribution throughout all branches of the Service. A typical analysis of 200 consecutive patient questionnaires at two separate treatment centers reveals the remarkable consistency of response which patients under the care of different medical officers have immediately after being shown the film.

1.   75% experience various psychosomatic reactions of which they are aware; viz: nausea, palpitation, abdominal discomfort, sweating, tremors, paresthesia, etc. These vary in intensity depending upon the patient's preparation. Seemingly well patients without preparation sometimes show marked reactions.

2.   52% state they have startle reactions. These have also been documented by direct observation and infra-red audience photography. It should be noted that this occurrence is despite the fact that the background battle sounds (explosions, rifle and gun fire) are muted to the point of minimal audibility. Here again the degree of preparation is an important determinant.

3.   86% state they are vividly reminded of their own battle experiences. In this regard, it should be remembered that only 30% had actually participated themselves in a similar type of jungle warfare, e.g., 70% of the entire group were naval personnel whose combat experience has been limited to sea duty.

4.   70% state that they identify themselves with the characters and the events portrayed.

5.   76% say that they feel that the film helped them to understand more clearly the nature of Combat Fatigue.

6.   45%, according to their own statements and documented observation, continued to be emotionally aroused for two days following the first showing of the film. They state they sleep poorly, experience more disturbing dreams, feel restless and irritable, sweat more, and are "jumpy." This undercarriage of tension can be used readily to accomplish beneficial abreaction and a constructive cathexis. Patients in this vulnerable state are amenable to integrative psychotherapy.

Despite the expectation of wide variability in response, there is on the contrary a surprisingly high rate of similarity of behavior and reaction which is significantly immediately apparent to the numbers of the group themselves. A further analysis shows that almost universally in new patients unprepared for the realistic portrayal of a commonly traumatic experience, there is an almost critical exacerbation of symptomatology; however, in sharp differentiation those patients who have been in therapy for even a brief period are better able to integrate their experiences and therefore profit by an opportunity to abreact and analyze their induced reactions, either in personal terms or vicariously in terms of the film characters. Like drugs or other potent therapy, therapeutic films have the capacity for inciting response whose benefit is proportional to the skill and judgment of the therapist.

As Mitchell (8) has pointed out, the use of audio-visual aids has many objectives. They help the patient:

1. To consider many factors in accounting for his own and other people's behavior.

2. To be more objective about this behavior.

3. To distinguish the real reasons prompting this behavior instead of the superficial rationalizations which he uses to explain and justify his attitudes and motives.

4. To be more tolerant of others' attitudes and acts which are contrary to his own.

5. To undertake constructive action in such a way that more opportunities are presented for better human relations.

The war has shown that survival in our culture depends upon the ability of the individual to adjust himself to social change, drastic changes in the constellation of inter-personal relationships. Man possesses the potentiality for this adjustment; what is required is the development of kinetic techniques which will enable him to evolve the requisite behavior patterns easily and with less cost in terms of conflict and unhappiness. Therapeutic films can condense the chronology of social and psychic events in such a manner that a life-like emotional participation on a trial scale is possible. Functional behavior patterns can be purposely developed and the task of psychiatric education and rehabilitation can be greatly facilitated.

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AUDIENCE REACTIONS TO THERAPEUTIC FILMS

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INTRODUCTION

In his new book on psychodrama, the chapter dealing with therapeutic films,* Moreno says: "In the last few years a number of motion pictures have been produced, as Lady in the Dark, Now Voyager, Conflict, Love Letters, Spellbound, which represent a dabbling of the motion picture industry with therapeutic (often with straight psychiatric) projects. Due to the fact that the instigators, producers and actors have no psychiatric and psychological training, these films can well be classified as 'pseudo' therapeutic. Because of the mass influence which motion pictures exercise they can be called dangerous undertakings, spreading false notions, portraying untrue explanations of causes and distorted cures upon the screen. Upon closer analysis of these films as to their content, the influence of psychoanalytic theory is one of the outstanding features. The import of childhood trauma, of dreams and repressions are some of the most popular hypotheses used for the explanation of psychic conflicts. However, there is in these motion picture productions a feature much more involved which is not so obvious, the psychodrama. The psychoanalytic situation is a patient-physician relation, it is a form of verbal interview; the real stuff of life, the situations and conflicts, when and as they occur, are kept out of it. But the producers of these films do not try to duplicate psychoanalytic interview as it occurs in fact, which would be rather boring to the public; *they try to produce a 'drama,' to show that by enacting and re-enacting of scenes a mental catharsis can be produced.* Unconsciously therefore, they have been entering into the domain of the therapeutic drama or, as it is usually called, the psychodrama. When preparing the script, selecting the actors, editing and cutting the film, weighing the effects of the film upon audiences, factors and ideas are introduced by them borrowed from psychodrama, which they make up without sufficient knowledge of its principles of producing therapeutic films and of problems involved in audience catharsis. Unconsciously they are using,

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*Therapeutic film, a term coined and defined by Moreno, as "a type of motion picture whose main object is the treatment of audiences." See Psychodrama Monograph, No. 11, p. 13.

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during the production, the warming up of actors (always with the idea in view whether the audiences will be similarly warmed up), auxiliary ego methods, the process of role-playing and role-identification, which have become valuable concepts in the analysis and guidance of audiences.

"Such rapid popularization of an idea would be flattering, were it not for the increasing number of seemingly psychiatric motion pictures turned loose upon the public by unskilled men, producing undesirable effects. An important medium by which masses of people can be treated simultaneously has come into the hands of laymen who are unwittingly promoting a form of quackery which may become the greatest barrier to the psychodramatic film of the future."*

Moreno's pioneer films "Spontaneity Training" produced in Hudson, N. Y., in the autumn of 1934, were shown to two types of audiences, one consisting largely of college students, adolescents, mostly female, comparable in age, though not in social and academic background to the subject in the film, Audience I. The second type of audience consisted mainly of teachers and professional workers, a mature adult audience, Audience II. The difference in reaction to the films was striking and will be discussed later. Sitting in as participant observer the author attempted to collect and analyze these reactions.

DESCRIPTION OF THE FILMS

The motion pictures are entirely extemporaneous and though they had been made more than eleven years ago, it is pertinent to state that no one experienced them as dated, and that their age did not in any way detract from their impact upon the audience. In order to understand the motives given for the audience reactions, we are describing here the salient points of the films shown. The first film is an introduction to the warming up to and subsequent transfer of simple spontaneity states, as for instance, a sculptress starting a new creation in clay, a mother visiting her daughter at a boarding school, a girl waiting for someone who does not come, a business executive calling for greater efforts from her staff, a hospital supervisor giving instructions to nurses in an emergency. Criticism and interpretation from the director followed each performance, no scene was repeated. The second film is a therapeutic film. A young girl from a well to do home, but of emotional instability, after having failed in the past in regard to various social

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*Psychodrama, Collected Papers, Volume I, Beacon House, New York, 1945.

demands, learns how to become a waitress. We see her first without train-
ing, in the role of a waitress in a restaurant. From the start the subject
reveals, besides her deficiencies as a waitress, many personality difficul-
ties which are analyzed and treated, not apart from the vocational task,
but in conjunction with it. The film shows her development in the role of a
waitress, before, during and after the treatment. Fellow students in the
film watched her in her first attempt when she got into a heated argument
with one of her customers, taking sides for and against. These co-students,
chosen because of similar difficulties and interests to sit in on this subject's
training, were learning via mirror technique. Some of the most important
features of the films are that they copy in procedure psychodramatic sessions
in the flesh; the director interviews the subject, assigns a role for her.
The subject warms up to her role by physical starters as, arranging the water
glasses, setting the table, etc., aided by an auxiliary ego who takes the part of
the restaurant hostess. Two other auxiliary egos appear as guests who sit at
the trainee's table. Resistances were interpolated by the director, who had in-
structed one of the auxiliary ego guests to make a complaint in reference to
the subject's service. The guest stated that the waitress brought her coffee
although she asked for tea. This mild reprimand caused an immediate argu-
ment on the part of the subject. Verbatim reports and records of all actions,
gestures and carriage were made by a fellow student. Upon completion of
the scene every co-student in the film made her comments, criticising the
subject's behavior. The director analyzed the total performance, noting
weaknesses to be especially dealt with in further training. The complete
records were copied and handed to each of the students who took them home
to study. The next scene shows the subject at home, reading over her report
and realizing her error, demonstrating with a friend how she *should* have
acted. The last part of the film shows the same girl after several months
of spontaneity training again in a restaurant waiting on customers. She
showed poise, composure and ability to handle the implements and her clients
with facility. Training consisted first of a period of learning to handle the
dishes and silverware without customers; later customers entered into the
situation, girls well liked by the subject who offered no interpersonal con-
flict or criticism to the trainee. During a later phase of training more diffi-
cult assignments were given as for example, students to whom the subject
was indifferent, and lastly, girls who were rejected in the actual life setting
by the subject were placed opposite her. In this final phase conflict situa-

tions were produced which the trainee learned to master. Again records of every session were made and criticism of the co-students *within* the film carefully noted and an analysis made by the director.

REACTIONS, AUDIENCE I

Our audience participation ranged from full and partial *role-identification* to total rejection of the subject. This adolescent type of audience produced responses which were tinged with a good deal of emotion, as for instance in complete role identification: "That was me. I could just see myself. I always seem to get into trouble with people. I am a salesgirl in a department store but that is the kind of training I need, it would make a world of difference to me." — "I never saw anything so simple and yet fantastic in my life, and she learned so quickly." — "I thought it was so real. I too, would have quarrelled with the customer." — "She did a wonderful job. Imagine standing up in front of your classmates and taking all that criticism from them. She's got courage." The partial enthusiasts reported: "I might have thought those things, but I would never say them. The customer is always right." — "She learned well, but she should not have argued with her guest." — "I could never be a waitress, even with training." — "I don't think I could have done that well." Rejections were few in this type of audience, but several critical remarks were made: "She was silly, she looked as if the guest had committed a crime." — "All that fuss over a cup of tea." — "If I'd been the guest I would have walked out." — "It was a good thing she was trained, she'd never have been able to hold a waitress' job otherwise."

REACTIONS, AUDIENCE II

This type of audience, that of adults and professional workers showed little role identification with the subject and verbally produced largely intellectual reactions: "To what extent did the training in this specific situation enable the subject to deal adequately with other life situations, and was training limited to this type of situation only?" — "It was amazing to see her progress, but I would have liked the film to show more of the steps in her training." — "Why was treatment and training not directed at her immediate life conflicts?" — "We can appreciate that the fact that co-students were watching her and offering comments would be quite a factor in her ability to take it. I don't believe she would have

accepted criticism so well from adults." — "Were the girls sitting in on training only taught by indirect, spectator methods, or did they also get a chance to appear as subjects?"

DISCUSSION OF AUDIENCE PARTICIPATION

The participation quotient of Audience type I was considerably greater than that of type II, ranging from 73% to 89%, in audiences of similar construction to whom these films were shown, in the first type, from 31% to 42% in the second. The amount of catharsis received and observable in the first type was thus significantly greater than in the second. The latter showed irritation, rejection, conflicts and endless questioning. It would seem that the amount of catharsis obtained from therapeutic motion films by the audience depends upon: a) the problem portrayed; b) the type of actor; c) the solution to the problem; d) the type of audience and, e) the interaction between the members of the audience. Each of these factors contribute to the amount of participation and role identification possible on the part of the spectators.

CONCLUSION

This sort of inquiry leads us to believe that the limitation of the therapeutic film is that, especially as it is able to stir up audiences, many spectators may leave the theatre with a number of conflicts sensitized and dormant problems reawakened without being able to satisfy and resolve what it has activated. The follow-up, indeed, the completion by an actual psychodramatic session under skilled guidance appears to be the only alternative to an otherwise risky therapeutic undertaking.

HISTORICAL SURVEY

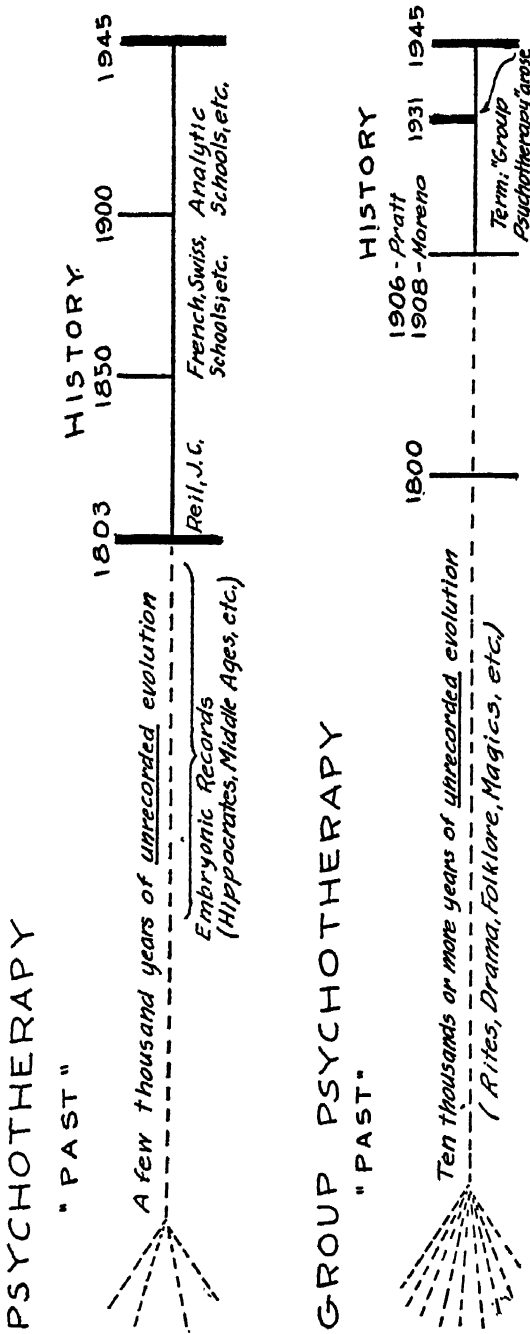ORIGINS AND DEVELOPMENT OF GROUP PSYCHOTHERAPY

A Historical Survey, 1930-1945

JOSEPH I. MEIERS, M.D.

Of the growth of Group Psychotherapy we may readily say the same as of the evolution of Psychotherapy proper—these words which the well known psychologist Ebbinghaus used once when speaking of the development of his field, Psychology: "It has a long Past but a short History." This apparent contradiction is, indeed, but a nice way to illustrate the enormous number of almost untraceable roots which both Psychotherapy and Group Psychotherapy have in far antiquity. The history of cults and religion, of folklore, folk tales and poetry, of Egyptian, Greek, Oriental, East Indian, Chinese, Polynesian and last but not least our own American Indian medicine provides ample fields of the "Past" where these roots can be found. On the other hand, by "History" of both Psychotherapy and Group Psychotherapy we mean nothing but the course of either of these healing arts in the form of well recorded and "systematized" disciplines; specialties within the ever growing realm of our Civilization, aging into rigidity and striving for rejuvenation. It would be of interest to demonstrate how this contrast of "long past" and "short history" becomes even more paradoxical in a comparison of the coming age of both: the concept of Psychotherapy and that of Group Psychotherapy. However, we will leave its proof for another occasion. (Fig. 1)

In this connection it might be of interest to quote the almost prophetic words of Johannes Christian Reil (1759-1813) who in his "Rhapsodies on the Application of Psychic Methods in the Treatment of Mental Disturbances," said in 1803 that ". . . the medical Faculties will soon be obliged to add to the two existing medical degrees (of medicine and of surgery JM) still a third, namely, the doctorate in Psychotherapy", he thus becoming the coiner of this new term. (Let us ask ourselves, just in passing: has Reil's claim been quite realized within these 150 years?)

The term Group Psychotherapy, the name for the "younger" branch of the "psychic method" of the Art of Healing, seems to emerge in recorded form first in 1931. Witness the words of the late William Alanson White.

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PSYCHOTHERAPY
"PAST"

HISTORY

1803 1850 1900 1945

A few thousand years of *unrecorded* evolution

Embryonic Records
(Hippocrates, Middle Ages, etc.)

Reil, J.C, French, Swiss, Analytic
Schools, etc, Schools, etc.

GROUP PSYCHOTHERAPY
"PAST"

HISTORY

1800 1906 - Pratt 1931 1945
1908 - Moreno

Term: "Group
Psychotherapy" arose

Ten thousands or more years of *unrecorded* evolution

(Rites, Drama, Folklore, Magics, etc.)

Designe Dr. J.J. Meiers

FIG. 1 "PAST" AND HISTORY OF PSYCHOTHERAPY
AND GROUP PSYCHOTHERAPY

White, in his introductory remarks as chairman to the Special Conference during the meeting of the American Psychiatric Association held in Philadelphia in 1932 and referring to the meeting held at Toronto in May 1931, recorded Jacob L. Moreno as having "suggested group psychotherapy," in the Report of the Conference on "The Application of the Group Method to the Classification of Prisoners".[1]

Many things have happened since the now historical Philadelphia meeting to show that it was deeply meaningful that William A. White, then superintendent of St. Elizabeths Hospital, Washington, D. C., watched over the initial phase of the development of Group Psychotherapy in the U. S. A. as an officially recognized method. Since the Conference on Group Method took place in 1932, whence emanated the earliest organized influence of Group Psychotherapy upon the psychiatrists of North America, White himself sponsored the introduction of sociometrically grounded group study into St. Elizabeths Hospital. It was the late Dr. Winifred Richmond, Chief Psychologist at St. Elizabeths at that time, who reported Moreno's group procedure applied to a group of nurses at the hospital in 1936. Doctor White again, later on, took interest in the first establishment of the psychodramatic method of group psychotherapy in the United States.

And in 1940, it was Dr. Winfred Overholser (W. A. White's successor as superintendent of St. Elizabeths) who, assisted by Margaret Hagan, Field Director of American Red Cross, made possible the founding of the first Theatre for the Psychodrama in the largest federal mental hospital in this country.

Thus it was completely in keeping with the focal role of St. Elizabeths Hospital has played in the development of group psychotherapy and psychodrama in America, that Dr. Roscoe W. Hall, its clinical director, was asked to act as the chairman of the latest Conference on Group Psychotherapy at the Centennial Meeting of the A.P.A. in Philadelphia, May 1944.

Today, as group psychotherapy has penetrated as a fact and is even more establishing itself as an "idea" in the minds of ever widening ranks of physicians, psychiatrists, pedagogues, penologists, occupational therapists,

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[1]Published by the National Committee on Prisons and Prison Labor, New York, 1932, republished elsewhere in this symposium on page 15. See also J. L. Moreno, "Group Method and Group Psychotherapy," published in 1931, chapters on Group Therapy, pp. 60-61, Illustration of Group Therapeutics, pp. 92-94, and The Application to the Institution for the Insane, pp. 95-97. See also *Who Shall Survive?*, 1934, pp. 301 and 429 on Group Therapy and Group Psychotherapy.

and so on—doesn't it sound almost incredible that this very term was introduced into our vocabulary less than 15 years ago? Yet, this writer at least has not been able to trace it, so far, in the literature prior to that date. We want to show in the following investigation how, during its relatively brief history, the concept of group psychotherapy has comprised a gamut of many different and in some ways even contradictory methods and approaches.[2]

THE MOTHER SOIL OF EARLIEST GROUP PSYCHOTHERAPY

Before, however, turning to a survey of these manifold schools of modern group psychotherapy it appears justified to ask ourselves: What made for the "kairos", the propitious moment of its birth? Why did it arise just at the time it did?

This much can be said: After approximately 50 years of the existence of the various psychotherapeutic methods (mainly in France and Switzerland) and after the rise of the psychoanalytic methods—*all* of these centered upon the individual alone—it seemed inevitable that someone had to feel that the advantages of individual psychotherapy should be extended to the greatest possible number of sufferers. Here, too, necessity became the mother of invention. However, as so often in history, it was *not* the adherents of existing schools of individual psychotherapy (hidebound as most of them were in their specific methods) who felt the urge and therefore "hit upon" the close-lying vein of group therapy.[8] Here, again "outsiders" struck the ore.

THE PRECURSORS

It is true, some approach to group psychotherapy was made even by one or another of the individual-centered schools.

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[2]However varied they are, they have at least one common denominator. Group psychotherapy treats individuals in groups and can be *contrasted* with the concept of individual psychotherapy in which a person is treated as an individual only. This contrast is by no means effaced by the fact that many (if not most) group psychotherapeutic methods allow or employ—either in principle or in certain phases—the use of the "individualistic" treatment of their group members, too.

[8]In this connection, it might be of interest to mention what George H. Alexander wrote, as late as 1940, in his "Psychotherapy and the Psychotherapist—New Orientation," an otherwise highly interesting paper: ". . . There is a lamentable lack of adequately trained psychotherapists now available to handle the large number of patients who seek treatment . . . ," etc. (In *Psychosomatic Medicine,* vol. 2, July 1940.) *Group Therapy* is never as much as alluded to, in that extensive article.

For instance, it was a practice in the consultation polyclinic of Alfred Adler and his Individual Psychology students of Vienna, that in consultation with neurotics (mainly children) *after* an initial "individual" exploration, other persons, parents, students and even non-belonging parties might be present at the discussion of the case with the juvenile.

However, this was more in the way of a by-product, never developed into "straight" group therapy.

It may seem a sheer coincidence that the earliest and most typical founders of true group psychotherapy were two men who started from entirely different angles. One, a medical doctor in the highly industrialized America of the first decade of this century, was J. H. Pratt of Boston. He, as early as 1906, introduced "mass instruction" into the treatment of tuberculous patients. This he gradually extended into classes of instruction and encouragement, by many psychological devices, of psychoneurotics and what now might be called sufferers of "psychosomatic" cases. It was in April 1930 that the first class of what was subsequently called "Thought Control" convened. Typical for the importance and specific weight of the group members in Pratt's movement is the fact that the name "Thought Control" was given not by him, but suggested by one of his first class members. His example was followed not only by his personal students and co-workers but has found following and extensive application in various fields, for instance work with children having reading difficulties; in some state hospitals, etc., far beyond its original locale of application—the outpatient clinic for psychoneurotics.

The other early creation of a methodology that later was to become the fully developed sociometrically and psychodramatically based group psychotherapy, originated in Vienna, a big city which, like Boston, was a centre of industry and a metropolis of learning. Moreno started to practice group psychotherapy by using three different approaches.

The first approach led to psychodrama. He started around 1909 in the form of staging written plays with children and juveniles, but soon passed over to the completely *original* practice of "letting them play spontaneously" their own problems on self-creative primitive stages in the since famous Vienna Meadow Gardens (Augaerten). In 1911, Moreno created "together" (as he himself insists) with hundreds of children and adolescents a "children's theatre for spontaneity" where the first recorded psychodramatic sessions were produced. In one of them, "The Godhead as Comedian" Moreno let it be known: ". . . The theatre up to now has mirrored before

our eyes the pains of alien things; tonight, however, it has played to us our own woe. . . ." Out, of this developed in the early twenties the "Stegreif Theater" for adults in Vienna and the Living Newspaper.

The second and third approach led to sociometry. He began, around 1911, by formulating a plan of how the problem of prostitution could be helped. This led to the forming of self-help groups, initiated and run by the girls themselves. The change from a symbolic to a personal status as members of the community, instead of as outcasts, had a cathartic effect. The method of not trying "to reform" them but to arouse the dynamic factors operating within their own groups as a lever towards the realization of their aims, proved highly beneficial. A third approach was made in 1916 in Mitterndorf near Vienna—a place of enforced "relocation" of South Tyrolian (Italian) peasants—when he proposed to the Austrian adminis-· tration a form of "group therapy" (meant to adapt these war victims in the best possible way to their new residence) that was based on the prin- ciples of *sociometric* group analysis.

He brought these ideas to the United States in 1927, started a "thera- peutic (Impromptu) theatre" and further developed the application of sociometric analysis to psychotherapeutic influence upon various "groupings" in situ: at Sing Sing Prison (New York) and at the N. Y. State Training School for Girls. All this matured towards the "Group Plan" which became the topic of the above mentioned conference in 1932.

Thus originated what we know in the U. S. A. today as the psycho- dramatic and sociometric methods, with their ever expanding applications in psychiatry, schools, training of nurses, penological work and so on.

It deserves to be mentioned that within that early period, S. E. Jelliffe wrote his important article (too little known to most): "Psychotherapy and the Drama" (1917). In it we find these significant statements: ". . . the drama is the work of Art which has most adapted itself to (this kind of) therapy. . . ."

THE PIONEER PERIOD

It was in the second part of the twenties that Trigant Burrow wrote most of his papers about the "group method of analysis", the earliest being "Social Images Versus Reality" (1924).

From 1935 on, especially in America, the activities and various begin- nings of group psychotherapy become too numerous to be pointed out here by the single names of authors: founders or followers. The springs have become rivulets, and these have merged into streams. It was the late Giles

W. Thomas who, in 1943, wrote the first comprehensive survey "Group Psychotherapy, A Review of the Recent Literature". In this paper he attempted, following Freudian principles, a categorization of group psychotherapy but only in one plane: by opposing the mutually-polaric principles of "analytic" on one side, with the "repressive-inspirational" approach on the other. This categorization comprises only the differentiation as to the ideational "content" with which the group of patients is approached by the therapist (leader), *analytic* versus *repressive-inspirational* method, both of which "poles" fall, in practice, mainly into the didactic (lectural-discussional) sphere (see Figure 1, No. III). Thomas' paper is regarded by this writer as an aid in understanding the history and some principles of group psychotherapy. In its goal, at least, it reaches beyond being a mere "review of the literature."

But Thomas showed in his informative paper at least one serious shortcoming. Although he mentions the various *psychological* entities, for instance: assurance, insight, identification with therapist-leader, etc. (as brought forth in the reports of the many research workers and "practitioners" of group psychotherapy) and made the "application" of those entities more or less responsible for their successes, he did not go far enough in seeking out the *other principles*: Structure of the Groups, Forms of Activities, Role of the "one" (leader-therapist) *vs.* the "many" (the whole of the group or audience); the essential difference between Lecture-Explanation *vs.* group-member Interaction in free discussion and dramatic, spontaneous Self-presentation—all of these principles (and some more) underlying the action and effects of group psychotherapy. It is, thus, not a matter of chance that Thomas, although he mentions the psychodramatic procedures at some length (pp. 173-4), fails to notice that in his "analytic vs. repressive" polar scheme there is simply no room to place the dramatic-interactionally accented types of group psychotherapy—because these types transcend beyond that "polarity", encompassing both its poles. Further, Thomas failed to notice the basic importance of the sociometric foundation underlying the activity of the various types of group psychotherapy: the preceding exploration of the social atom, etc.

Moreno has been generally recognized as the chief exponent of psychodrama and sociometry. But what has been known to a small group has never been made fully clear to the profession at large: he has been also chief mover in the development of a scientifically based group psychotherapy. Moreno was the first to see the need (1) for knowing the Dynamic Struc-

ture of Groups as *prerequisite* to the therapy of groups, and (2) for systematizing such knowledge. The impressive development of sociometry in the last twenty years presents itself at the same time as the inventing and sharpening of instruments for valid diagnosis of dynamic group structure. Various methods of the *self-direction of groups* and *therapeutic re-grouping* arose on the basis of adequate group diagnosis. Moreno established the view that *no* form of group therapy,—whether didactic (lecture, discussion), psychoanalytic (interview of patients in front of the group, and interpreting their complaints by means of psychoanalytic concepts), esthetic (motion pictures and other visual aids)—ought to be undertaken and can be called scientific *unless* the "object" (a group in situ or a specific group before the therapist) has been diagnostically explored as to its psycho-socio-cultural organization.

BASIC CATEGORIES IN GROUP PSYCHOTHERAPY

We now propose to introduce the following main pairs of polaric categories:

I. The *didactic* approach vs. the dramic:[6] The didactic method being represented *best*, that is, most typically (though by no means solely) by Pratt's "Thought Control classes; the dramic, by Psychodrama of Moreno.

II. To view the whole of Group Psychotherapeutic approaches under a more structural angle:

Type 1 (the kyriotropic).[7] Here the leader, or therapeutic instructor, has in the given set-up the overwhelming (or at least, overweighing) role, thus influencing as it were "from above" each patient-member separately: aside from the undeniable additional creation of a "mass fluid" atmosphere without which any successful group work is impossible.

To this Type 1, belong *all* of the more *didactic* or indoctrinating groups, like "Thought Control" and similar lecturing methods; also, most of the "group-analyses" schools.

Type 2 (the koinotropic).[8] The inter-action of the members, in fact

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[6] *Drámic* is introduced specifically because the word "dramatic" has already too many well-defined meanings and associations. The other word derived from the Greek *dráo* = "do, act" would be "drastic", which in its turn is also too much loaded with conserved associations.

[7] "Kyrio-tropic", from *kýrios*, Greek = "the master". Thus, "kyriotropic" = "turned towards the master."

[8] *Koiné*, Greek = "community"; thus, "koinotropic" = "turned", or "leaning towards the community."

From these words easily can be derived the nouns: kyriotropism vs. koinotropism.

the "living-himself-out" (on a spontaneity stage, or in other actions) of *each* patient and the sum total of these actions and their inter-action is what is prevalent in this type of method; whereas the "director" stands by, at times entirely non-interfering, in the background. This Type 2 in its greatest purity is represented, to my knowledge, by psychodrama (and sociodrama) of J. L. Moreno.

Fig. 2

TABLE OF CATEGORIES OF GROUP PSYCHOTHERAPIES[4]

I. As to the Constitution of the Group:
   Amorphic *vs.* structured ("crystalized") group

II. As to Sources and Transfer of Influence:
   Leader-centered *vs.* group-centered method
   (Kyriotropic *vs.* (Koinotropic)

III. As to Mode of Influence:
   "Lectural *vs.* "Dramatic" (inter-actional) method
   or (didactic" *vs.* "dramic")

IV. As to Form of Procedure:

Spontaneous	*vs.*	"Aforethought" Form
(Freedom of experience and expression; therapist, or speaker [from inside the group] is extemporaneous; the audience unrestrained)		(Suppressed experience and expression; therapist memorizes lecture or rehearses production; the audience is prepared and governed by fixed rules)

V. As to Locus of Treatment:

Situational	*vs.*	Derivative method
(Treatment in "loco nascendi", in situ)[5] (For instance: in family, in camp, etc.)	.	(Treatment in an artificial or constructed situation) (In clinics, etc.)

VI. As to Goal of Treatment:
   Causal *vs.* Symptomatic

Of course, between these typical "poles" of group categories, there are such in-between features as, for instance, the "Club" system described by J. Bierer (1943) in England. It seems to develop on its three different

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[4]This Table of Categories is partly based on Moreno's scheme of classification, see p. 318 in this issue.

[5]"In other words, psychological treatment is projected away from the clinic into real life situations, and techniques for a proper procedure to be used on the spot, developed." J. L. Moreno, "Group Method and Group Psychotherapy," Beacon House, Sociometry Monograph, No. 5, page 94, New York, 1931.

"levels" (in-patients and out-patients of a mental hospital, for both sexes), a pretty strong self-activity of the patients' group, with the psychotherapeutic leader keeping more or less in the background.

As another of such "intermediate" approaches one may mention the psychotherapeutic "venture" devised by this writer (Meiers) in 1943-44 in Philadelphia and successfully repeated later: the method of "Informal Talks by a Patient, on a topic 'best known' to him, before a group of co-patients, with discussion."
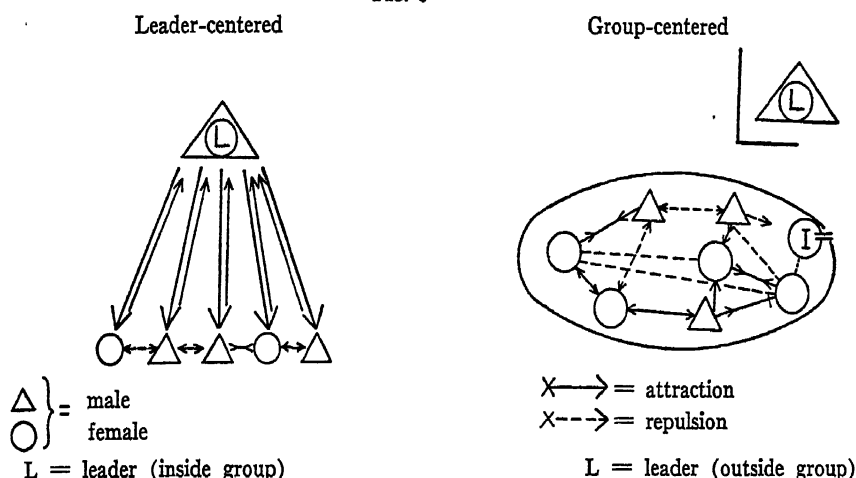
> One patient is induced to volunteer a talk; the topic is left to him but taken preferably from the field of his closest interest (work, hobby, etc.). However, the approximate theme is agreed upon—if time allows —by the group beforehand (one or two days in advance) so as to avoid a topic that might be hard to understand or boring to the majority. This method seems to have at least three advantages: (1) it strengthens the self-confidence of the "orator or patient" in his abilities in many respects (concentration, self-expression, etc.), thus is an excellent means for a "finishing touch" before discharge; (2) gives both pleasure and confidence to all other group members that one of them is so *able*—and so will they be, and that every topic which each of them will choose in turn, will be equally interesting and acceptable; (3) it can be applied either with little preparation or on the spur of the moment (spontaneously) and is often even better the latter way. The therapist is left completely "out of the circle" (although he may attend "as a guest"); sometimes he may be needed or of help to start the patients' discussion on the "talk", or to keep it going, with gentle, humorous prodding. This, however, is needed generally only in the beginnings of the "Club"; subsequently he may discuss the talk and its discussion with individual patients or with the group.

TENDENCIES WITHIN THE VARIOUS SCHOOLS OF GROUP PSYCHOTHERAPY

A few more words may be allowed about what is felt by this writer to be a certain tendency, or even may be called a "shift", inside the whole of modern group psychotherapy, both in this country and apparently also in Great Britain. (Information of progress, if any, in the rest of Europe unfortunately has been unavailable to me so far.) It appears that the "inter-actional" and "dramic" type of group psychotherapy (the koino-tropic method that tries to accentuate the self-activity of the group as a whole and of its members and keep the "director" in the background) comes to the fore and gains momentum. There is no denying that this impression might be, at least partly, a result of "wishful thinking", as in this matter there is hardly any statistical yardstick available as yet. How-

ever, this impression has been strengthened especially during this war when many recent writers clearly seemed to stress—consciously or even unconsciously—this point in the presentation of their work, even those outside the psychodramatic-sociometric orbit proper. Some examples will be given in the next section.

FIG. 3

Leader-centered   Group-centered

△ } = male
O }   female
L = leader (inside group)

X——→ = attraction
X---→ = repulsion
L = leader (outside group)

THE DEVELOPMENT DURING THE WAR (1939-1941-1945)

Already before the outbreak of World War II in 1939 and its engulfing the United States in '41, there had been an ever growing expansion of the various group-psychotherapeutic units, older and newly budding. This expressed itself in their numerous publications which markedly increased the bibliography especially since 1942-43. (It should be remembered that earlier endeavors are reflected often in rather late reports.)

However, it was the war with its accelerating "demands" for group psychotherapy (both extensively and intensively) that became a real challenge to all the various schools and units. Most of them came forward with new projects and plans to meet the emergency, preferably in the military field, submitted them often for approval to various government agencies and, of course, especially to the responsible neuropsychiatric leaders of the Armed Forces. Some civilian needs (children, mothers, youth) were not overlooked though. All this reflects itself in our literature listing. It is too early, however, to even attempt to evaluate with the sharp tool of *statistical analysis* the problem of *how successful* group psychotherapy as a whole has been in meeting the needs *during* the war from 1939-45:

First, in an over-all sense in the percentage of success (recovery or improvement of neuroses and psychoses; in the "prevention" of child and youth delinquency, etc.).

Second, in a *comparison* of its different methods and schools, with each other, in all these fields.

Third, in a *comparison* with individual psychotherapeutic methods (where such comparison should be feasible), for instance with the "brief therapy" methods put forward by some leaders in psychoanalysis; also compared with individual narcosynthesis and other similar methods.

Fourth, questioning ourselves candidly how much group psychotherapists themselves (and the general public) *expected* from this specialty—and what shortcomings have shown up and what were their *causes.* The last inquiry seems especially important for the role group psychotherapy ought to play in the hard (and probably not to restful) *postwar period.*

Even though it seems that we have not yet sufficient bases for such vast and necessary comparative-statistical investigations, a few single questions and problems may be touched upon.

There is what E. A. Strecker has called in his introduction to "Psychiatry in Modern Warfare" the missed "responsibility of psychiatry" between the two wars, its *lag* in learning the lesson of World War I to prepare itself for the onslaught of the following world cataclysm. Confronted with this self-criticism of the older and more official discipline of academic psychiatry—can the young and, so to speak, youthful community of group psychotherapy *afford* to subject itself to less serious searching of the soul?

Did group psychotherapy do enough in the war? Was it allowed to do more? Whence did serious faults, bureaucratisms, etc., arise?

In contrast to such stern and, maybe, uneasy questions of self-clarification, there are doubtless some brighter points to be considered, some of them, it seems, of extreme theoretical and practical interest.

There is, first of all, what may be called the official *recognition* of group psychotherapy and psychodrama by the War Department.

War Department Technical Bulletin 103 stated that *group* therapy has advantages over individual therapy in dealing with suspicious, hostile and guilty feelings and minimizes personal feelings.

It is suggested that groups be homogenous, patients be seen individually first and then in groups . . . from 7 to 25 individuals meeting three to six times weekly for about one hour.

War Department Bulletin, TB MED 84 recommended in the section on Treatment Methods:

(f) *Dramatics.* To be used in impromptu form (psychodrama of Moreno) as group psychotherapy. If talent is available, the use of short skits, musical numbers, and pantomime.

But besides this, so to speak, accolade given to the abstract concept of group psychotherapy by the leading public experts, we have to record other important acknowledgments.

Thus R. R. Grinker and L. A. Spiegel in their new book *Men Under Stress* say:

> "Dealing with groups has a positive value in that the group more nearly approximates the state of the human being in his natural surroundings, as a gregarious animal seeking a satisfactory niche in his social setting. His inhibitions and repressions are motivated by the mores of the group. By working out his problems in a small way, he should be theoretically able to face the larger group that is his world in an easier manner."

Even with the qualifying limitation of the word "theoretically", the above quotation appears to be quite a step forward in favor of group therapy, considering Grinker's pre-war position of strict psychoanalyst.

There is another testimonial—one of many—from official or semi-official sources. To Howard P. Rome was given the opportunity of writing a special chapter on "Military Group Psychotherapy" in the Manual of Military Neuropsychiatry (1944). Nobody interested in group therapy should omit this brief and concentrated report on the application of group psychotherapy methods for the streamlining of (convalescent) neurotic battle casualties; and this holds good no matter how much the views of some group therapists may differ on the question as to whether this kind of psychologic "regimentation", as it were, of the souls should be called psychotherapy. (In parenthesis it may be noted that Rome (page 564) shows himself strongly opposed to the *deadening force of routine:*

> ". . . occupational therapy is too often as detrimental as boredom since it stifles initiative and incentive, and leads to discontentment. Only *creative, satisfying* (italics mine, J. I. M.) activity [with a military reference] should be a part of a convalescent program."

Does that not sound almost like a eulogy to Moreno's spontaneity? Thus confirming the same "shifting of the accent" on the group-centered, interactional[9] type of group psychotherapy—even within such a strict lecture program as Rome's—the shift which we had pointed to in the foregoing section.

Maybe some of the readers will agree with the feeling of this writer: that the fact that hundreds of thousands of servicemen and women and

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[9]See Fig. 2. and 3.

officers and, moreover, thousands of physicians in the Medical Corps have personally experienced and obtained at least a glimpse of group psycho-therapy "in action", *might* prove almost *more* important for the future significance of this branch of medicine within our national body—than the existence of any number of printed articles and acknowledgments, valuable as they are.

<div align="center">*   *   *</div>

There is still another rather surprising instance where group psycho-therapy within the war has shown its mettle—in the "guise", as it were, of an individual psychotherapy.

We read in the report on "War Neuroses in N. Africa" by Grinker, or in the extract therefrom "Narcosynthesis, a Psychotherapeutic Method for Acute War Neuroses", the following excellent, highly dramatic descrip-tion (page 3):

> ". . . frequently, especially among the milder anxiety states the patient *does not live out* (italics mine) the scene in the present but tells it as a story . . . ;"

and especially on page 4:

> ". . . some patients who talk constantly throughout the [drug induced (J. I. M.)] session 'to their friends', become blocked at certain points of emotional height.
>   The therapist then *plays the part* (italics mine, J. I. M.)of the friend stepping, as it were, into the battle scene proper in an active role. He discusses plans of action, ways of evacuating the wounded comrades or whatever is cogent to the particular situation *in order* to further the progress of events in hand."

Could anyone familiar with—for instance—psychodramatic group psy-chotherapy devise the picture of an "auxiliary ego" truer to form than this *individual* (narco-synthetic) psychotherapist who has turned group thera-pist—as it were "in spite of himself"?

We have permitted ourselves to call attention to such choice morsels and interesting examples of undiluted group psychotherapy "in sheep's clothing" only because otherwise they would have passed unnoticed; we are sure that the reader will get his fill of frank and unadulterated group psychotherapy applied during wartime from the listed literature.

As an unusual aspect of the application of group psychotherapy to modern war,[10] we want to list here the plan for "mass" psychotherapy as

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[10]This paper is quoted here specifically in view of the significance its topic may

preventive psychiatry (of newly inducted soldiers) as presented by R. R. Cohen ("Factors in Adjustment to Army Life . . ." etc., in *War Medicine*, vol. 5, pp. 83-91 Feb. 1944). As far as we can see Cohen's "plan" constitutes merely a highly schematized "prophylaxis" for rookies by means of lectures, for instance against homesickness and other psychic ailments of undigested Army life, lectures with posters and schematic pictures, but, as it seems, even without discussion. Still, no matter how "rough" this indoctrination may appear and how far from what many might be inclined to call psychotherapy, we have to try to learn from it, especially as the author reports that his preventively "psycho"-treated soldiers' group was found by the Army superior to controls.

Another interesting war item may be quoted: S. Sherman's "System of *combined* individual and group therapy as used in medical program for merchant seamen." (In *Am. J. Psychiatry*, vol. 100, pp. 127-130, July 1943.)

In closing this section on the inter-relation of group psychotherapy and this war, it might be of interest to know what E. A. Strecker stated: "The extensive use of group therapy has been one of the *innovations* of World War II." It was used, however, Strecker goes on to say—"in World War I by Strecker and Hadfield". Hereto might be added what Dr. McPherson stated in the discussion to S. B. Hadden's paper on group psychotherapy (Transact. Amer. Neurological Assn., 1943, pp. 132-135): "Sidney Schwab in the last (1914) war demonstrated how effectively the group can be used as an adjunct to therapy with the individual."[11] Of course the dimensions which the attempts at cures by group psychotherapy have assumed in this war *differ* as fundamentally from those in the last war as the dimensions of the wars themselves. But that refers not only to the numerical extension and expansion of the application of group psychotherapy; it has undergone a deep change itself largely through the introduction of the "dramic" inter-actional and koinotropic features.

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assume in case the United States continues universal (selective) compulsory military and naval training.

[11]The writer regrets having been unable to locate so far an original paper by Schwab describing this experience of his. This entire historical topic of priority may be—as it will seem to many a reader—of purely academic interest. However, it deserves mention in a sketch on development of group psychotherapy.

NON-MILITARY DEVELOPMENT OF GROUP PSYCHOTHERAPY DURING
THE SECOND WORLD WAR

Small as most "civilian affairs" have appeared and have been pre-
sented to the public eye during the volcanic days of the war, still: "life
had to go on." And so has the small, still way of science, pure and applied.
Purely theoretical and abstract research going on before and during the
war contrbuted to the development and self-clarification of group psycho-
therapy.

This again is reflected in the bibliography. We have two main parts
to consider: that brought forth by the psychodramatic-sociometric school,
which in itself produced, approximately within these last five years, the
bulk of group-psychotherapeutic titles. Aside from J. L. Moreno's own
fundamental monographs, I want to mention here specifically Z. Toeman's
"Role Analysis and Audience Structure" 1944. I commend this to the reader's
attention not only because it places "Special Emphasis on Problems of Mili-
tary Adjustment" and thus constitutes another instance of the contribution
of psychodramatic group psychotherapy to the war effort of the democra-
cies but even more because it represents an almost classic example of the
essence of the dramic-interactional type of group psychotherapy and its
most important aspects and techniques. As said before the publications
connected especially with the psychodramatic-sociometric sector of group
psychotherapy have become so numerous as to transcend any possibility
of detailed review here. In the other, the more "didactic" sector of group-
psychotherapeutic literature, I wish to name also only a few which appear
as of special theoretical interest: S. B. Hadden's "Group Psychotherapy,
Superior Method of Treating Larger Numbers of Neurotic Patients" (July,
1944); L. A. Schwartz's, "Group Psychotherapy in the War Neuroses"
(1945); and further, two contributions from England: W. R. Bion and
J. Rickmans, "Intragroup Tensions in Therapy: Their Study as a Task
of the Group"; and Donald Blair's, "Group Psychotherapy for War Neu-
roses", both published in 1943. (Of the latter, American readers find an
extensive and well orienting review in *Psychosomatic Medicine*, vol 6, Jan.
1944, pp. 100.) The above titles are pointed out mostly for their theoretical
interest or/and as most typical of the "didactic" approach. Still, for the
rest of the list goes the same as was said before concerning the psycho-
dramatic sector, namely, that all of these reports and research papers de-
serve attention.

Various Problems and Specific Fields in Modern Group Psychotherapy

There is a project, still in its initial stages, the introduction of group psychotherapy in state hospitals. Originally, when group psychotherapy was conceived by many from the point of view of "multiplying" the reach of the individual psychotherapist, there arose a great hope with many a well-meaning friend of the "underprivileged"—the "under-treated" mental state hospital patients, who constituted a mass of approximately *half a million* in the continental U. S. A. alone—before World War II! There have been, however—as far as this writer has been able to unearth—only relatively few papers about this important question, aside from stray remarks in general articles. Only as an example we mention the interesting more recent paper: G. L. Perkins' "Psychotherapeutic Aspects of State Hospital Psychiatry" (June 1943. Highly significant are the discussion remarks about it by Dr. Charles W. Read (Elgins State Hospital, Illinois): ". . . We have so little time to be spent on the *individual* patient. We want to get things done in a hurry. . . ." How true, how frank!

It is true, of course, that not only articles have been written on this topic but that also some practical attempts have been made to cope with this rather deficient situation where group psychotherapy would truly *come fully into its own.* Was it the rapid intervention of the mechanical device of the various shock therapies (which at best could support but never supplant group—and individual—psychotherapy if real healing is aimed at)? Was it the utter war-increased shortage of doctors, let alone of experienced psychotherapists in the large psychiatric hospitals? In any case, this field of group psychotherapy so far, it seems, has remained sadly *underdeveloped*—mildly speaking. Here especially, in the opinion of this writer, the "dramic" approach, if properly executed, could be expected to yield the best results and at the same time, would present the most *economic* procedure.

Projects on such a scale require the training of adequate personnel, especially the training of directors. According to Moreno a director has three functions, he is a producer, a therapeutic agent and a social analyst. These qualifications should fulfill the requirements for directing any group psychotherapeutic as well as psychodramatic sessions.

One thing is certain: efficient Group Psychotherapy is *not* a matter of a few medical (or not medical) geniuses or men of peculiar skill and gifts. It *can* be learned; and so it *must.* And the ones who alone will be

able to, and should set up the *standards* and the *schooling devices* for the growing number, throughout the country and the continents, of much needed Group Psychotherapists—are, no doubt, the heads and the co-workers of the existing successful group-psychotherapeutic units.

Another problem of greatest general interest appears to be that of the increased opportunity which modern Group Psychotherapy (as compared with individual psychotherapy) offers for confronting and, also, adapting the neurotic and the psychotic patient to the presence of the opposite sex.

It seems obvious that this far-reaching problem is better solvable in the sphere of group psychotherapeutic (especially in that of the interactional and dramic type) than in mere verbalistic devices of individual therapy alone. This question is, no doubt, so vast that we can merely point it out. We therefore limit ourselves to quote here from the report by J. Bierer (England) on "A New Form of Group Psychotherapy". ". . . the complication that might have arisen *but did not* (italics mine, J. I. M.) from mixing of sexes." And we would not pass up here the words said, in the discussion of that same paper, by T. P. Rees: ". . . I wonder to what extent the improvement noted by Dr. Bierer in his patients was due to the facilities provided for the free intermingling of the sexes. I am sure that segregation of the sexes at present (is) overdone in our (British—M) mental hospitals."

Last but not least, a few words about the progress made by Group Psychotherapy in using *other than verbal* techniques. The use of puppet shows (specially in children's Group Psychotherapy) is widely known. The employment of *moving pictures* along with or in addition to, verbal-dramatic devices, has become known in the last years, especially in Psychodramatics but also in connection with the (military) narco-synthetic methods (Grinker et al.).

We wish here to mention what seems to be less known—namely, the use of music (Moreno's Psychomusic) in connection with specific form of Group Psychotherapy. See: The Impromptu Orchestra, in *Impromptu* periodical, vol. I, No. 2, 1931.

Of no less interest but, probably, still less known is the group-psychotherapeutic factor involved in the application of the (so-called "fine") Arts —painting, sculpturing, etc. The very outstanding work of Ernest Zierer, in his Creative (Art) Therapy—although working generally with the individual patient and using Color Tensions and the feeling of Integration as main factors—employs to a considerable extent also group devices: collec-

tive wall picture painting, and certain group instruction and discussion of the students' community.

A last word may be appropriate about the passive role, so to speak, played by Group Psychotherapy in recent time: we mean by that the evaluation it has obtained as one of the "Projective Methods" available to human psychology for the gauging of "personality" factors. See: Helen Sargent, "Projective Methods, their origin, theory and application in Personality Studies". (Psychological Bulletin, May 1945).

A last question: Is it possible, is it even necessary, to measure with a purely *statistical* yardstick the extent of the progress which our method has made in the last ten or fifteen years in the awareness of it both among the educated, and of the general public?

There are, certainly, still entire "blacked out" spots in our map, provinces, as it were, both geographically and educationally speaking where *all too little,* if anything was ever heard yet of the very existence of Group Psychotherapy.

Is it significant (let us ask ourselves frankly) to note that in two of the newest books that have appeared in 1945 in the field of Psychiatry in the U.S.A. (Karnosh, L. J. and Zucker, E. M., "A Handbook of Psychiatry") in its 302 pages does not mention Group Psychotherapy at all. Whereas Sadler's "Modern Psychiatry" has on page 750, under the headline "Psychiatric Socialization" the following text: ". . . these isolated personalities should be encouraged to seek membership in those community groups engaged in various social, civic and philanthropic activities." Again, no mention, otherwise of Group Psychotherapy as a modern psychiatric agent.

Is such overlooking wholly the matter of "Ignorance, pure and simple", of lack of knowledge on the part of these and other authors? Should we, Group Psychotherapists, not conclude inversely that Group Psychotherapy as an entirety has so far done not *enough* to achieve renown in some more remote and/or "conservative" quarters?

ANALYSIS OF BIBLIOGRAPHY

Only such group researches are referred to in this survey which have the therapy of the group and the change of its dynamic structure as its main focus. For this reason, many sociological and socio-psychological titles of merit are not included.

On the basis of the bibliography appended the development of group psychotherapies can be divided into six periods: *first* period, from 1906-1914

(early work by J. J. Pratt and J. L. Moreno); *second* period, 1914-1919, First World War (contributions by Pratt and Moreno); *third* period, 1919-1932; up to the historic conference on Group Method in Philadelphia (contributions from Moreno, Pratt, E. W. Lazelle, 1921, and Trigant Burrow, 1924); *fourth* period, 1932-1934, up to appearance of Moreno's *Who Shall Survive?* (contributions from Moreno, Pratt, Helen H. Jennings, 1931, L. C. Marsh, 1931, Lazelle, Burrow); *fifth* period, 1934-1940 (Moreno, Jennings, Marsh, Burrow, Winifred Richmond, 1936, M. Schroeder, 1936, Paul Schilder, 1936, Louis Wender, 1936, S. R. Slavson, 1937, Shepard Wolman, 1937, Lauretta Bender, 1937, Newell E. Kephart, 1938, Kurt Lewin, 1938, Ronald Lippitt, 1938, Ernest Fantel, 1939, Frank Curran, 1939, Howard Rowland, 1939, Joseph Sargent, 1939, Anita M. Uhl, 1939, Bruno Solby, 1939, J. G. Franz, 1940, E. N. Snowden, 1940, Leona M. Kerstetter, 1940, Ruth Bordon, 1940, Leslie D. Zeleny, 1940); *sixth* period, 1940-1945, Second World War; during this period a considerable literature developed, only a few of the newcomers are mentioned (Margaret Hagan, 1941, Frances Herriott, 1941, William S. Dunkin, 1941, I. M. Altshuler, 1941, P. L. Smith, 1941, John K. Fischel, 1942, Lawson G. Lowrie, 1942, Fritz Redl, 1942, Samuel B. Hadden, 1942, Z. Toeman, 1942, Nathan W. Ackerman, 1943, Howard P. Rome, 1943, Stephen Sherman, 1943, Edward A. Strecker, 1943, Rose Cologne, 1943, Abraham Low, 1943, W. R. Bion and T. Rickman, 1943, T. P. Rees, 1943, I. Bierer, 1943, D. Blair, 1943, Florence B. Moreno, 1944).

SUMMARY

In this paper we endeavored to show:

1. The roots of Group Psychotherapy—as a yet unsystematized, pre-scientific activity, an attempt of self cure of early human groups; going, probably, even deeper than those of "pre-historic" individual psychotherapy.

2. The first emergence of the terms "Psychotherapy" (1803) and "Group Psychotherapy" (1931) is traced.

3. An attempt is made to show the "mother soil" for the originating of modern "Group Psychotherapy" at the time of its start.

4. The "Precursors" and originators of the earliest and, at the same time, most typical "schools" of Group Psychotherapy: the American, J. H. *Pratt* ("Thought Control Classes", Boston, Mass.) and (the Europe born) J. L. *Moreno* (Sociometry-based Group Psychotherapy and Psychodrama, Beacon, N. Y. and New York City).

5. The Pioneer Period.

6. The first historian of Group Psychotherapy, G. W. *Thomas* (1943). His categorization of Group Psychotherapy (merely "analytic" *vs.* "repressive-inspirational") recorded, evaluated and criticized.

7. Other viewpoints of necessary categorization are brought forth.

8. Tendencies within the various Schools of Group Psychotherapy; is there a "shift" towards the interactional-koinotropic type of Group Psychotherapy?

9. The Development during the War (1939-1941-1945); necessity of statistically founded self-criticism of Group Psychotherapy as a whole and of its various "schools" comparatively. Instances of achievements of Group Psychotherapy in this war emergency. Group Psychotherapy "in the guise" of Individual Psychotherapy. Group Psychotherapy as a means of *preventive* (military) psychiatry. Group Psychotherapy budding in World War I.

10. Non-military development of Group Psychotherapy during the second World War.

11. Various problems and specific fields in Modern Group Psychotherapy: *Administrative and allied problems*: I. Application of Group Psychotherapy in state and other larger mental hospitals. II. The problem of qualification and training of group-psychotherapeutic directors. *Therapeutic problems and technics*: III. The confrontation of the (neurotic and psychotic) patient with the opposite sex is apparently better solved—or at least better solvable—with the aid of Group Psychotherapy than by individual therapy alone. IV. Music and Group Psychotherapy. V. Art (the "fine arts") and Group Psychotherapy.

CONCLUSION

Group psychotherapy is "marching on." However, it appears that it is not being applied yet, either in North America or anywhere else, in proportion to its already proven, and to its potential usefulness.

One of possibly the best means, both for self-clarification among group psychotherapists in the broadest sense (i.e. all those actively interested in group psychotherapy) appears to this writer to be the convening of a well prepared national (and later an international) *congress* for the discussion of all current problems arising in this field in the post-war period.

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ADDENDA

1939

216. Huizinga   Homo Ludens (Man the Player), Amsterdam.

1944

217. William Malamud   The history of psychiatric therapies, in One Hundred Years of American Psychiatry. New York, 1944, p. (273)-323, American Psychiat. Association, N. Y.

THE FUTURE OF MAN'S WORLD

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The new outlook in psychiatry was perhaps most dramatically heralded in the single opening sentence of my best known opus: "A truly therapeutic procedure cannot have less an objective than the whole of mankind"—and as if to indicate that the fate of mankind may be imminently at stake, I gave the book the title, "Who Shall Survive."

As my idea of group psychotherapy has meanwhile taken historical proportions, it may be of more than human interest to report here the anecdotal background of this title. The first title was "Sociometry," but the late Dr. William A. White, who had written the Foreword to it in the summer of 1933, thought "Sociometry" a bit too technical and suggested "Human Interrelations." On second thought I felt that neither "Sociometry nor "Human Interrelations" expressed the core of the book, gave in to a brainwave and called it "Who Shall Survive" with the undertitle "A New Approach to the Problem of Human Interrelations." There has hardly been a review of the book which has not contained a derogatory remark about this title. Sociologists thought it funny for a sociological treatise. Psychiatrists found it strange for a contribution to psychiatry. Biologists said the title was biological, but it was not a biological book. Twelve years have gone by but the discussion concerning the title is not yet closed. In a university seminar a student made the remark that after careful reading, the title made sense: "It means that *everyone* shall survive, there is a place and an opportunity for all." A few weeks ago I received a letter from a distinguished psychiatrist saying: "The more time goes by the more the title 'Who Shall Survive' seems to reflect the basic situation of our age."

Broadly viewed, "Who Shall Survive" deals with two social issues, the relation of man to man and the relation of man to certain peculiar products of his mind, which when separated from him, can function independently. It boils down to an appraisal of the positive forces which man has at his command to meet two threats, the aggression coming from man and the aggression coming from "robots."* The answer to the first was sociometry. The answer to the second was creative revolution, based on a theory of

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*Robot derives from a Polish word robota, to work. My idea of the zootechnical animal (1918) was popularized a few years later by Karl Czapek in a play "Rossom's Universal Robots", 1921; he coined the term robot. But the term is not adequate as in

spontaneity. However, both have to work hand in hand in order that either should be effective.

The surface connotations in the title—"the survival of the fittest," with the added implications of racial arrogance have been over-stressed. The deeper connotations, *the survival of human existence itself* (not only of the fit;[1] fit and unfit are now in the same boat), of human creativity, of man's universe, have been overlooked. These enemies are common to all men, not only to one or another group; they are threats to the survival of the total universe of men. These odd enemies are *technical animals* which can be divided into two classes, cultural conserves and machines. The more popular word for them is "robots."* One of my earliest writings[2] was an exposé to their systematic study; I proposed a new science, "Die Zootechnik, Wissenschaft von den technischen Tieren," i.e., Zootechnique, Science of the Technical Animals. I put the analysis of the book into the foreground as a robot par excellence, referring to other types of robots which man has invented, such as the plow, cannon, money, and airplane. It discussed the two functions and relations of the robot towards man, as his friend and helper and as his enemy and destroyer. I gave particular emphasis to the apocalyptic character of the enemy robot, and painted a sinister picture of what the fate of man's world would be if no controls are developed against some of their vicious forms. "The parthogenetically procreated offspring exterminates the parent." "It is the threat of a world to come, completely mechanized, from which all cosmic remnants have perished."

The racial revolution and World War Number 2 have divided mankind into several camps, one fighting the other. But the invention of the atomic bomb has given us an excellent didactic lesson of how foolish inter-human wars are and how unstable and unsafe is the basis of all human

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the zootechnical animal not only work but also destruction is implied. Thus in my definition the working robot can become ferocious and vice versa. A better term than robot might have been genie. According to the Arabic use there were good and bad spirits among them who assumed the form of animals, giants and so forth. The robot is really a "zoomaton," zoo, from Greek zoon, animal (zoo, live), automaton, a Greek word, neut. Of automatos, autos, self plus mao, strive after.

[1]Fit and unfit, Darwin's survival of the fittest, have become increasingly "psychagogic" terms.

[2]Quotations are translated from Die Gottheit als Autor (The Godhead as Author, in Daimon, February, 1918, p. 7). See also Der Koenigsroman, 1923.

existence. We need one another but continue to fight each other. An enemy has appeared on the horizon which is an enemy to *all men*, which may make an end to all races, superior and inferior, fit or unfit, old and new. It is as if mankind has been awakened from a dream in which it indulged in the chronic and comparatively innocent war plays of its pre-bomb era. Shaken, it finds itself face to face with a *reality of the present and of the future,* the atomic bomb and its kins to come, unhuman but not unreal, unliving but not uncosmic. The answer to this great emergency (which has been anticipated in smaller doses in the course of human evolution and of which the invention of the fire, of the tool and of the book are outstanding examples) does not lie in palliative measures like counter-robots, an international police or a world society (which are, of course, fine things to aim at). The countermeasure lies in a cold appraisal of the situation, a systematic study of the causations underlying the invention of mechanical devices, the origin of the robot in human nature and beyond it, a careful calculation of the "socio-atomic organization of mankind." In other words, we should bring the problem into full scientific consciousness and develop parallel with sociometry a zootechnique, a science of the technical animals.

The invention of robots is largely a skill of *homo sapiens*. The reason for their origination is mysterious; perhaps "when man found himself failing in his struggle for maximum creativity he divided from his will to create his will to power"[3]—and now his will to *have* power turns against his will to create. Why should man want robots? It is perhaps the same reason, in reverse, as the one which at an earlier period made us want a God to whom *we* were robots. Therefore, if we could understand what we mean to God, we could understand what robots mean to us. Our relationship to God may be simply this—he needs a lot of helpers in order to put his creation over. Man too, has a program of living, of creation on a minor scale, he needs helpers and weapons to defend himself against enemies. But all animals do that without robots, they just multiply themselves. The biological robots of animal reproduction do not satisfy us men "entirely." There must be a deeper and additional reason why we wanted and created the technological kind. An analysis of spontaneous-creative processes broadened my understanding of the problem. Infants, immediately after birth demonstrate that the less spontaneity a being has the more it requires some-

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[3]See J. L. Moreno's Commentary to The Words of the Father, Beacon House, New York, 1942, p. 181.

one who has it, in order to survive. The infant lives on borrowed spontaneity. The humans who are at the beck and call of the crying infant, who come and carry, feed and comfort it, I call auxiliary egos. By auxiliary ego I do not mean the total person of the mother or father, for instance, but the "role" it has for the infant. Everything, however, which is outside of that role, frightens the child. An excess of spontaneity which that person turns upon the infant beyond or outside of the role appears to be an irritating factor. The infant seems to want its auxiliary egos perfect, that is, to have all their ready spontaneity available for him, the infant, and none for themselves, the egos. This offers a clue for understanding the relationship between the idea of the auxiliary ego and the idea of the robot. If the auxiliary ego could concentrate and conserve all its spontaneity for one function, the role which satisfies the needs of the infant would not permit any diversion of spontaneity for himself. He would be less real and human, but a more perfect auxiliary ego. These observations were confirmed by the attitude which children show towards dolls. The doll does not have the often unpleasant counter-spontaneity which real human beings have, but it has still some physical and tangible reality which pure fantasy companions do not have. In the half real, half mechanical doll world the child can act as an unhibited ruler. Here he gets the first taste of the robot which he can destroy at will and which may one day go out and act as decreed by him. Dolls seem to make the child free—free from other children and from adults. One can divide the *doll robots* as fulfilling two functions: the doll which represents a companion and friend, a mechanical role-player, a *domesticated* automaton; and then the doll as the object of unlimited aggression, the mechanical role-player who is fought and killed without having a defense, an *enemy* automaton. I have described elsewhere[4] how playing and long preoccupation with dolls encourages the child to treat animals and human beings like robots. In psychodramatic procedure we are using the auxiliary ego to do this consciously and systematically. The auxiliary ego sacrifices his own ego and produces roles in accord with the requirements of the patient. He extends the universe of the patient so that the patient can find new situations and new associates. The robot, like the auxiliary

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[4]See Towards the Curriculum of an Impromptu Play School, *Impromptu Magazine*, No. 2, 1931, Beacon House, New York. Also Sociometry and the Cultural Order, *Sociometry Monograph* No. 2, Beacon House, New York, 1943, and Das Stegreiftheater, 1923.

ego, makes man free from man and gives him an artificial sense of wellbeing and power. It too, extends the range of megalomanic experience to a new climax. But that is the limit of the similarities between the two. Behind the role-giving auxiliary ego is a warm, spontaneous being. The robot is lifeless. It is the same at every instant, it does not grow, it does not change. Once upon a time we envisoned our God as the one who could destroy us any time he wanted to. Robots, too, can give a single man the power to rule and perhaps to destroy the universe instantly. But they cannot produce an ounce of spontaneity.

A human infant results from the conjugation of a man and a woman. A robot results from the conjugation of man with nature itself. In both cases the offspring takes over some feature from both parents. In the robot, for instance, there is some feature of the man-producer and some feature of natural energy modified by him.

A descriptive classification of the various types of robots man has invented should precede their dynamic analysis. One type can be defined as the domesticated robot, the plow, the pen, the book, the type-writer; another type can be defined as the enemy robot, the gun, the rocket, the atomic bomb. Then there is the mixed form of robot, as a knife, a fire, steam engine, the automobile and the airplane, which can be used for and against himself. But because of the non-human character of the robot it can easily be turned from one function into another, the automobile can be turned into a wartank, a working knife can be turned into a weapon, the warming fire turned into a means for destruction. Many of the domesticated robots are blessed with the attribute of becoming labor-saving devices, which has, however, the unpleasant consequence that they at times reduce the need for creating, promoting with leisure also inertia. Robots are more precise and reliable than animals and human beings. Many of the robots have also the attribute in common of being able to affect human beings or other targets "at a distance," a book, a radio or a television sender can entertain or teach at a distance, like a gun, a rocket and an atomic bomb can kill people and destroy objects at a distance. The book is a robot par excellence. Once off the press, the parent, the producer, the author is immaterial, the book goes to all places and to all people, it does not care where it is read and by whom. Many robots have further in common the attribute of comparative immortality. A book, a film, an atomic bomb, they do not perish in the human sense, the same capacity is

always there, they can be reproduced *ad infinitum*. A book may have to be reprinted, a film copied on and off, but if anything perishes it is not their essence but some material entourage. Our human world is increasingly filled with robots and there seems to be no end to new forms and new developments. Since man came out of the jungle, its master, he did not have a similar maze of threats to face—the jungle of robots.

The control of the robot is complicated for two reasons, the one reason is that the robot is man's own creation. He does not meet it face to face, like he did the beasts of the jungle, measuring his strength, intelligence and spontaneity with theirs. The robot comes from within his mind, he gives birth to it. He is confounded like every parent is towards his own child. Rational and irrational factors are mixed therefore in his relationship to robots. In the excitement of creating them he is unaware of the poison which they carry, threatening to kill his own parent. The second reason is that in using robots and zoomatons man unleashes forms of energy and perhaps touches on properties which far surpass his own little world and which belong to the larger, unexplored and perhaps uncontrollable universe. His task of becoming a master on such a scale becomes a dubious one as he may well find himself more and more in the position of Goethe's Sorcerer's Apprentice who could unleash the robots but who could not stop them. The apprentice had forgotten the master's formula, we never had it. We have to learn this formula and I believe it can be learned.

The fate of man threatens to become that of the dinosaur in reverse. The dinosaur perished because he extended the power of his organism in excess of its usefulness. Man may perish because of reducing the power of his organism by fabricating robots in excess of his control.

The conclusion is that as parents and creative agents we produce more perfect robots than we produce babies. As our perfectionism has failed us again and again in its application to us as biological and social beings, as individuals and as a society of individuals, we give up hope and invest it in automatons. The pathological consequences are enormous. Man turns more and more into a function of cultural and technological conserves, puts a premium on power and efficiency and loses credence in spontaneity and creativity. The two countermeasures suggested are the sociometric approach to group relations and spontaneity training.

The use of physical atom energy can be directed and controlled by

"social atom energy."[5] Man has never recognized and used in full the power pent up in the millions of social atoms continuously formed by him and his fellowmen. If he would, robots like the atomic bomb would be to a "sociometrically integrated mankind" what a doll is in the hands of a child. "If a fraction of one-thousandth of the energy which mankind has exerted in the conception and development of mechanical devices were to be used for the improvement of our cultural capacity during the moment of creation itself, mankind would enter into a new age of culture, a type of culture which would not have to dread any possible increase of machinery nor robot races of the future. The escape would be made without giving up anything that machine civilization has produced.[6]

Epilogue

A system of society must be realized, to which all individuals belong spontaneously, not only "by consent" but as "initiators"; without exception, not 99.9 per cent, but literally and numerically *all individuals alive*. The "one" individual left out may turn out to become the singular *scientist-criminal* using means of lethal destruction, not towards one or another fellow man (Cain vs. Abel) but towards the total race of man, his total world.

Man must take his own fate and the fate of the universe in hand, on the level of creativity, as a creator. It is not sufficient if he tries to meet the situation by technical control—defense weapons—nor by political controls—world government—he should face himself and his society in *statu nascendi* and learn how to control the robot not after it is delivered, but before it is conceived (creatocracy).

I have often described the revolutionary period during the last hundred and fifty years in terms of three phases: the economic, the psychological and the creative revolution. In economic ideology the robot was greeted as a benevolent, labor saving and comfort bringing agent. It made the poor and the rich the owners of technical slaves. To some it seemed to hold promise of solving the class conflict. In the ideology of the psychological revolution—at least in its most recent demoniac form, using racial and political phraseology to cover up psychological causations—the robot became an agent of destruction. The number of men could be reduced without loss, now that the kind and number of robots could be multiplied without

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[5]Who Shall Survive, pp. 141-157.

[6]Who Shall Survive, pp. 364-65; also "Creative Revolution," p. — in Impromptu, (1931).

limit. In the ideology of creative revolution the robot is finally seen in relation to the creative act itself.

Could we imagine a congress appropriating two billion dollars for "social atom" research? Maybe it is not and will not be appropriated because what matters is not money. Mankind may need still more serious setbacks before it comes to its "creative revolution." Perhaps it is unavoidable that the present human civilization be destroyed, that mankind be reduced to a handful of individuals and human society to a few scattered social atoms before a new rooting can begin. Christianity too, has not been helped by mass baptism of babies; fewer but self-realized Christians might have meant more true Christianity.

The battle between zoon (living animal) and zoomaton approaches a new peripetie. The future of man depends upon counterweapons developed by sociometry and group psychotherapy.